DEPARTMENT OF ECONOMIC SECURITY

DIVISION OF DEVELOPMENTAL DISABILITIES

DEVELOPMENTALLY DISABLED/ARIZONA LONG TERM CARE SYSTEM (DD/ALTCS)

FEE-FOR-SERVICE PROVIDER MANUAL

December 2005

Covered Services List (cont.)

Contacting Us

Health Care Services (HCS), a unit of the Division of Developmental Disabilities (DDD), is responsible to coordinate the acute care services for persons with developmental disabilities who are enrolled in the Arizona Long Term Care System (ALTCS). We appreciate your assistance in the delivery of these acute medical services.

Our staff want to communicate with you to ensure that you understand what services are covered, which services require authorization, and how to be reimbursed for services you provide. If you have any questions, please call, write, or fax us at the following numbers:

Offices:	Health Care Services 2200 N. Central Ave., Suite 207 Phoenix, Arizona 85004-1420	602/238-9028 phone 602/238-9294 Fax
	Prior Authorization 2200 N. Central Ave., Suite 506 Phoenix, Arizona 85004-1420	602/238-9028 phone In Arizona: 1-800-624-4964 602/253-9083 Fax
	Flagstaff Office 2705 N. 4th St., Ste A. Site Code 300F Flagstaff, AZ 86004	928/773-4957 phone
Robert Klaehn, M.D. Medical Director		602/542-6826
Louette Coulson, RN, BSHS Administrator, Health Care Services		602/238-9028 x6013
Jon Hash Program Operations Manager		602/238-9028 x6008
Provider Relations		
	Beth Gonzales, LPN, Supervisor	602/238-9028 x6010
	Donna Badaglialacqua, RN	602/238-9028 x6026
	Sherri Ashbaugh, RN	928/773-4957 x2222
Member Services		
	Alice Gonzales	602/238-9028 x6029
Behavioral Health		
	Tyrone Peterson, Behavioral Health Manager	602/542-6829

Utilization Review	
Agnes Reynolds, RN	602/238-9028 x6038
Jeanette Grissom, RN	602/238/9028 x6110
Prior Authorization (PA)	602/238-9028
Kathy Juarez, RN, PA Manager	602/238-9028 x6035
Aggie Reynolds, RN	602/238-9028, x6038
Kathy Juarez, RN, Acting EPSDT/MCH Coordinator	602/238-9028, x6035
Trudy Trudell, RN	602/238-9028, x6036
24 hour/7 days Contact No.	1-800-624-4964
DES/DDD Early Childhood Coordinator	480/231-0960 phone
Ida Fitch	480-488-3713 fax
1789 W. Jefferson	
Phoenix, AZ 85005	

Introduction to the Division of Developmental Disabilities

Introduction to this Manual

This Provider Manual is intended for health care providers delivering services to persons eligible for services from both the Division of Developmental Disabilities and the Arizona Long Term Care System. More information about these federal and state funded programs is in the next section.

In particular, this Manual is intended to explain the services covered, which services require prior authorization, and how to be reimbursed for services rendered to persons who are eligible for services but not enrolled in a Division subcontracted health plan. The list of **covered services**, found in the section titled Covered Services, explains the service and indicates whether **prior authorization** is required from Division personnel. **Claims submission** requirements are outlined in the section titled Claims.

If you have any questions about the contents of the Manual, or want a replacement copy, please contact the Provider Relations telephone number(s) listed on the Contacting Us page in the front of the Manual.

Organization and Funding

The Department of Economic Security (DES) is a social service agency of the Arizona State government. The Division of Developmental Disabilities (DDD), a sub-unit of DES, exists to advocate for and provide services to persons with developmental disabilities.

This Provider Manual is addressed to providers of health care services to persons whom the Division serves. The Manual will describe

- what services are covered,
- how to be reimbursed for service delivery, and
- how to contact staff of DES/DDD.

Funding for covered health care services comes from both the federal government (Medicaid) and the state of Arizona. The Arizona Health Care Cost Containment System Administration (AHCCCSA) funnels federal funds from the Centers for Medicare and Medicaid Services (CMS) to DES/DDD for persons and services covered under Medicaid.

AHCCCSA administers two health care programs: one, the Arizona Health Care Cost Containment System (AHCCCS), is for persons who need ambulatory health care services; and the second, the Arizona Long Term Care System (ALTCS), is for persons who are at risk for institutionalization due to their need for services. AHCCCSA contracts with DES/DDD to provide services to persons who quality for DDD and

ALTCS services. ALTCS covers a mix of acute care, long term care and behavioral health services. DES/DDD uses state funds in conjunction with federal funds to provide these services.

The **acute care** services (e.g., physician office visits, prescriptions, lab and x-ray services, hospital admissions, medically necessary transportation) are coordinated through the office of Health Care Services (HCS). Staff of HCS include nurses who perform utilization review and quality improvement activities, and support staff who verify member eligibility and enrollment and work with provider offices to answer any questions.

ALTCS **long term care** services (e.g., personal attendant care, habilitative therapy, or respite care) are coordinated by the DDD Districts. DDD is a statewide program, serving persons with developmental disabilities in all fifteen Arizona counties. The state is divided into six (6) Districts to facilitate local communication with residents in all counties. District staff include Support Coordinators (also called Case Managers) who are responsible to ensure eligible persons receive the services for which they qualify, and nurses who can authorize needed care in the home setting and/or coordinate medical care needed in hospital or nursing facilities. The District staff are responsible to contract with providers of long term care services, as well as authorize and coordinate these services.

Background and Philosophy

DES/DDD believes in the principles of individual dignity, respect and self-direction for all persons with developmental disabilities. The goal of DES/DDD is to assist persons to grow, develop and achieve their unique potential. DES/DDD recognizes that the family is the primary caregiver for the person with developmental disabilities and should be consulted and involved in all care and service decisions. It is the role of DES/DDD and its providers to assist persons with developmental disabilities and their families in exercising their rights by adopting and implementing these principles and philosophy in the delivery of services. DES/DDD requires providers to take affirmative action to ensure that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference or physical or mental handicap.

Qualifying for DD/ALTCS Membership

Persons with developmental disabilities are eligible for certain services provided through the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). ARS Section 36-551 and the DES/DDD Policy and Procedures Manual define developmental disability as a severe chronic disability which:

Is attributable to:

- Mental retardation
- Cerebral palsy
- Epilepsy
- Autism
- Developmental delay (age 0-5 years)

Is manifested before the person attains age eighteen (18) years;
Without appropriate intervention, is likely to continue indefinitely;
Results in substantial functional limitations in three or more of the following areas of major life activity:

- Self care
- Receptive and expressive language
- Learning
- Mobility
- Self-direction
- Capacity for independent living, and
- Economic self-sufficiency; and

Reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary or generic care, treatment or other services, which are of lifelong or extended duration.

DES/DDD determines the person's eligibility for DES/DDD programs based on documentation of the above criteria. All individuals determined by the Division to meet the above criteria are eligible to receive long term care services from DES/DDD. AHCCCS determines which of these individuals are eligible for the ALTCS program.

DES/DDD has been providing ALTCS services since 12/19/88. Delivery of the long term care benefits is coordinated by DES/DDD personnel in the six DES/DDD Districts statewide. To deliver the ALTCS acute medical benefits, DES/DDD contracts with ambulatory health plans serving all fifteen Arizona counties. Most persons eligible for ALTCS and DDD services receive acute medical services through a subcontracted health plan; however, some members are not enrolled in a health plan. ALTCS members not enrolled with a health plan are eligible to receive covered services from the fee-for-service (FFS) providers to whom this Manual is addressed.

ALTCS Eligibility Determinations and Enrollment Specifications

AHCCCSA determines the person's eligibility for ALTCS based on financial criteria and an assessment of the person's functional, medical, nursing, and social needs. Financial eligibility is defined in ALTCS Rules and includes income guidelines for Supplemental Security Income (SSI) and Temporary Assistance to Needy Families (TANF).

All individuals determined to be eligible for ALTCS shall apply for any health or accident insurance benefits to which they are entitled. All insurance and other third party liability benefits shall be assigned and transferred to DES/DDD and AHCCCS (and by extension to the medical service provider) for covered services provided during the period of ALTCS eligibility.

ALTCS Medical Eligibility (Preadmission Screening)

AHCCCSA uses the Pre-admission Screening (PAS) process to assess medical eligibility. The PAS is used to determine if the individual is "at risk" of institutional placement in a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR).

PAS results are reported to DES/DDD, and are available to fee-for-service providers and subcontracted health plans. This information is the foundation for the member's service plan developed by DDD staff (see next paragraph regarding the ISP). If the person is not already eligible for DDD programs, DES/DDD then evaluates the person's needs and determines eligibility for services provided through DES/DDD.

For individuals meeting eligibility criteria, DES/DDD is required to provide case management data, including placement and the proposed Individual Support Plan (ISP) to AHCCCSA within thirty (30) days of enrollment with DES/DDD. If the proposed ISP includes services that require written authorization by the person's Primary Care Physician (PCP), DES/DDD Support Coordinators (formerly called Case Managers) will request input from the PCP to complete the proposed ISP.

The Division's Medical Care Program

The design of the Division's medical care program is very similar to that of AHCCCS. It is the Division's intention to contract with ambulatory health plans and fee-for-service providers to form a statewide network capable of delivering the highest quality medical services to persons with developmental disabilities. Administration of the Division's medical care program is provided through the Health Care Services (HCS) Unit. An organizational chart of the Unit is included in this Provider Manual (see Appendix A: HCS Table of Organization).

Providers of Health Care

Within the Division's medical care program, the PCP is the gatekeeper for medical services. The gatekeeper's function is to be the single provider coordinating the medical needs required for each of the Division's members. The PCP is responsible for administering medical treatment, for referring to other providers, and for monitoring the member's treatment throughout enrollment in the DD/ALTCS program.

Contracted Health Plans and Special Services

It is the Division's intent to subcontract acute health care services to ambulatory health plans. The Division holds subcontracts with Arizona Physicians, IPA; Capstone Health Plan, Inc.; Mercy Care Plan; and Care 1st Healthplan Arizona. These health plans are responsible for providing acute health care services to DD/ALTCS members throughout the State of Arizona. In counties or geographic service areas (GSAs) where contracted health plans provide the medical services, the Health Care Services Unit is responsible for providing technical assistance to the plans and for providing oversight of the delivery of service.

The Division also interacts with the Indian Health Service (IHS) and Children's Rehabilitative Services (CRS) to complement the Division's FFS and subcontracted health plans' provision of medical services. In addition, certain DD/ALTCS members eligible for behavioral health services may receive service through the Regional Behavioral Health Authority (RBHA). The RBHA is an organization under contract with

the Arizona Department of Health Services to administer the provision of covered behavioral health services in a geographically specific service area of the state to eligible members, including DD/ALTCS eligible members.

Members Served on a Fee-For-Service Basis

The goal of the Health Care Services Unit is to provide high quality, cost effective medical care in a manner that is sensitive to the individual member's needs In the event that a specific county or geographic service area (GSA) does not have an available subcontracted health plan to provide services, the Division will contract with individual health care providers on a fee-for-service (FFS) basis. FFS providers are not required to contract with the Division to render services to eligible persons; however, each provider must be registered with AHCCCS and have a Provider ID number.

The Unit is responsible for provider recruitment and contracting. The Unit also operates as a health plan in the areas of prior authorization, referral, EPSDT coordination, claims processing, quality management/utilization review and risk management.

Regardless of member enrollment with a subcontracted health plan or a FFS Provider, the Health Care Services Unit, through its Member Services and Provider Relations staff, also assists members in accessing services and works with contracted providers to implement the delivery of quality care.

The Provider Relations Unit currently has representatives located in Phoenix and Flagstaff who provide training and consultation throughout the state. They are available Monday through Friday from 8:00am to 5:00pm. Providers can reach a Provider Relations staff member in Phoenix by calling 1-602-238-9028, ext. 6025 or ext. 6026. Provider Relations staff may be reached in Flagstaff by calling 1-928-773-4957, ext. 2222. (See Contacting Us in the front of this Provider Manual for HCS Provider Relations staff contacts, and Appendix A for Provider Relations Geographic Assignments Map.)

Provider Registration

The FFS Provider must be registered with AHCCCSA as an approved service provider. Possession of an AHCCCS Provider Identification Number is required for a provider to be paid through the Division.

The FFS Provider must also have on file with DES/DDD a current W-9 form (Request for Taxpayer Identification Number and Certification). If the provider's name, tax ID number, or address changes, a new W-9 must be completed and forwarded to your Provider Relations Representative.

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The Division's Health Care and Monitoring System

The purpose of the Health Care and Monitoring system is to augment the medical care program delivered through either subcontracted health plans or FFS Providers. The system may include, but is not limited to:

- Community nursing (periodic assessment and planning)
- Skilled nursing services (assessment, planning, intervention, collaboration and intermittent care)
- Discharge planning from acute care settings
- Team case management, including a R.N. for ventilator dependent members
- Nursing consultation

The provision and availability of the Division's health care planning and monitoring system varies from county to county, depending on resources and staff available. It is expected that appropriate understanding and collaboration among providers will reduce the overall utilization of medical services. The Division's health monitoring system staff want to work with you, the provider. To contact nursing personnel in your area, call the person listed in your county (see Appendix B: District Nurse Contacts).

PCP Assignment

DD/ALTCS members who are not enrolled in a subcontracted health plan will be assigned to a primary care physician (PCP) who agrees to work with DES/DDD. The member will be given the opportunity to choose his/her PCP. Failing a timely choice, the member will be assigned to the PCP with an office closest to the member's residence.

Members may change PCPs by calling the HCS Member Services Representative. * Members will be encouraged to develop a workable patient/physician relationship to ensure continuity of care; however, if the member wants to change PCPs, the new choice will be honored. If the Member Services Representative notices that a member has changed PCPs multiple times, s/he will contact the member's Support Coordinator to develop an action plan to encourage the member to develop a workable patient/physician relationship.

PCPs may request that a member not be assigned to him/her. Call your Provider Relations Representative to discuss such a request. Difficult members must continue to be provided services. (See **Difficult Member Arrangements in the PCP section** of this Manual.)

*As of 10/1/99, a subset of DD/ALTCS members in foster care were assigned to FFS

PCPs. In the event of a request to change PCPs, the member will be enrolled in a subcontracted health plan. The FFS PCP will be notified that the member is no longer assigned to the PCP.

Verification of DD/ALTCS Eligibility

HCS distributes an ID card to FFS members, which identifies DES/DDD as the health care provider. For members assigned to a subcontracted health plan, the subcontracted health plan distributes a health plan ID card to the member. Members are asked to present the health plan ID card whenever they access medical care (in PCP's and specialist's offices, at laboratories, pharmacies, hospitals, emergency rooms, etc.).

Eligibility can be verified by calling the DDD Member Services Representative at (602) 238-9028 (Monday through Friday, 8:00am - 5:00pm) or at 1-800-624-4964 (24 hours per day/7 days per week). Prior authorization must be obtained from the appropriate staff (either health plan or HCS) and claims submitted to the appropriate party. Ask the member to show their ID card to verify this.

Other Medical Insurance

DD/ALTCS members may also have other medical insurance coverage. Members and responsible persons are asked to inform medical care providers of all available medical insurance, including Medicare and private insurance. Providers should inquire about insurance coverage at the first contact with the member and should update insurance information at the time of each office visit. FFS Providers are required to bill any other insurance, including Medicare prior to billing DES/DDD for any DD/ALTCS (Medicaid) covered service. (See **Provider Reimbursement for Services** in this Manual.)

Co-Payments

DD/ALTCS members are not required to pay co-payments.

For example, well-child visits and prenatal care visits do not have co-payments, and there are no co-payments for lab, x-ray, pharmacy, or office visits.

Interpreter Services

Interpreter services are available for DES/DDD fee-for-service providers. To schedule interpreter services, please contact the member's DDD Support Coordinator. If you do not know the name and telephone number of the member's Support Coordinator, contact your Provider Relations Representative or Member Services at 602/238-9028, extension 6029. You will need to provide the member's name, date of birth and ID number when calling.

Provider Reimbursement for Services

All claims for covered services should first be sent to applicable third party payers (including Medicare and private insurance companies). If complete payment is not made by other insurance, the claim accompanied by the other insurance Explanation of Benefits, should be submitted to:

DES/Division of Developmental Disabilities
Business Operations/Acute Care Claims Unit
1789 West Jefferson, Site Code 791A
P.O. Box 6123
Phoenix, Arizona 85005

Capped Fee For Service Schedule

Approved services are reimbursed according to the AHCCCS Capped Fee-For-Service Schedule (CFFS). You may request a copy of the CFFS by calling the Provider Relations staff in your area. In this Manual, CFFS refers to all AHCCCS mandated fee schedules for provider reimbursement, including the fee-for-service schedule for outpatient, non-hospital charges; hospital per diem and cost-to-charge ratios; and the maximum allowable cost for pharmacy claims. DES/DDD reimburses all hospitals in Maricopa and Pima counties at the AHCCCS mandated hospital reimbursement rate, regardless of the county of residence of the member admitted to the facility.

Claims Submission

The PCP and other service providers must submit claims on the standard forms mandated by AHCCCS and CMS (Center for Medicare and Medicaid Services) – formerly HCFA (Health Care Financing Administration):

- Form CMS 1500 must be submitted for professional services, transportation, and durable medical equipment.
- Form UB92 must be submitted for inpatient hospital services, outpatient, emergency room, and hospital-based clinic charges and pharmacy charges for services provided as an integral part of a hospital service. Additionally, the UB-92 is used to bill for dialysis clinic, nursing home, free standing birthing center, residential treatment center, and hospice services.
- ADA Form for dental claims.

All claims must include the AHCCCS provider ID number and AHCCCS coded categories of service assigned to the billing provider. Verification of your AHCCCS provider ID number and approved categories of service may be obtained by calling AHCCCS, Provider Services, at (602) 417-7670, option #5. The in-state toll free number is 1-800-794-6862. The out-of-state toll free number is 1-800-523-0231. Submittal of

incomplete claims will result in a denial of payment.

Payment on UB-92 claims will be made by the Division within 30 days of receipt of a clean claim. The reimbursement amount will be according to the AHCCCS hospital charge calculation. Payment on CMS 1500s and ADA Forms will be within 60 days of

receipt of a clean claim. The reimbursement amount will be according to the applicable AHCCCS Capped Fee-For-Service Schedule.

Claim Submission Deadlines

Claims must be originally submitted within six (6) months of the Date of Service (DOS), and reach clean claim status within twelve months of the DOS. Claims not meeting these deadlines will be denied.

Claim Reference Number (CRN)

A Claim Reference Number (CRN) is assigned to all claims on each submission to DES/DDD. The first five characters of the CRN represent the Julian date the claim was received by DES/DDD. The remaining numbers make up the claim document number assigned by DES/DDD. A new CRN is assigned to a claim when it is resubmitted or adjusted.

Claims Completion Instructions

UB-92
The following instructions for completion of the UB-92 claim form should be used to supplement the information in the AHA Uniform Billing Manual for the UB-92.

Note: All **bold type** fields are required by DES/DDD. Failure to complete these fields may cause the claim to be denied. An asterisk (*) next to the number of a bold (required) field indicates required if applicable.

Field	Name/Status	Instructions
1.	**Provider Data**	Provider's name, address, and phone number.
2.	Unassigned	Not required.
3.	Patient Control No.	Account or bill control number assigned by provider. DES/DDD will return this number as a cross reference on Remittance Advice.
4.	**Bill Type**	Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See UB-92 Manual for codes.
5.	**Fed Tax No.**	Federal tax identification number.

Field	Name/Status	Instructions
6.	**Statement Covers Period**	Beginning and ending dates of billing period in MM/DD/YY format.
7.	Covered Days	Total number of days not covered by a primary payer.
9.*	**Coinsurance Days**	Number of regular Medicare Coinsurance days used during billing period. Applicable only to Medicare crossover claims.
10.*	**Lifetime Reserve Days**	Number of regular Medicare lifetime reserve days used during billing period. Applicable only to Medicare crossover claims.
11.*	**Group Provider ID**	ID number of authorized group biller that bills on behalf of and receives payment for services rendered by service provider.
12.	**Patient Name**	Recipient's last name, first name, and middle initial as they appear on recipient's HCS card.
13.	Patient Address	Street address, city, state and zip code.
14.	**Patient Birth Date**	Recipient's birth date in MM/DD/YY format.
15.	**Sex**	Male (M), Female (F)
16.	Marital Status	Married (M), Single (S), Unknown (U), Widowed (W), Divorced (D), Legally Separated (X).
17.	**Admit Date**	Admission date in MM/DD/YY format. Required for all inpatient, outpatient, and dialysis claims.
18.	**Admit Hour**	Code which best indicates recipient's time of admission. Required for inpatient and outpatient claims. See UB-92 Manual for hour codes.
19.*	**Admit Type**	Required for all inpatient claims. See the UB-92 Manual for Admit Types. Admit Type of "1" required for emergency inpatient and outpatient claims. 1. Emergency: Patient requires medical intervention for severe, life threatening or potentially disabling conditions. Documentation must be attached to claim. 2. Urgent: Patient requires immediate attention. Claim marked as urgent will not qualify for emergency service consideration.

Field	Name/Status	Instructions
		3. Elective: Patient's condition permits time to schedule services. 4. Newborn: Patient is newborn. Newborn source of admission code must be entered in Field 20.
20.*	**Admit source**	Enter code that describes the admission source: Adults and Pediatrics: 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from hospital 5 Transfer from skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/Law enforcement 9 Information not available Newborns: (Refer to Field 19) 1 Normal delivery 2 Premature delivery 3 Sick newborn 4 Extramural birth
21.*	**Discharge Hour**	Required for inpatient claims. See UB-92 Manual for codes.
22.*	**Patient Status**	Recipient's status for billing period. 01 Discharged to home or self-care 02 Transferred to another short term general hospital 03 Transferred to SNF 04 Transferred to ICF 05 Transferred to another type of institution 06 Discharged to home under care of organized home health service organization 07 Left against medical advice 08 Discharged/Transferred to home under care of home IV provider 20 Expired or did not recover 30 Still a patient 40 Expired at home (hospice only) 41 Expired in hospital, SNF, or ICF (hospice only) 42 Expired, place unknown (hospice only).

Field	Name/Status	Instructions
23.	Medical Record No.	Number assigned to recipient's medical/health record by provider (not the Patient Control Number).
24.-30.	Condition Code	Enter appropriate condition codes which apply to this bill. See UB-92 Manual for codes.
31.	Unassigned	Not required.
32.-35. (a-b)	Occurrence Code and Date	Enter appropriate code(s). Enter date(s) in MM/DD/YY format. See UB-92 Manual for codes.
36. (a-b)	Occurrence Span Code and Dates	Enter appropriate code. Enter From and Through dates in MM/DD/YY format. See UB-92 Manual for codes.
37.	Internal Control #	Not required.
39.-* 41.	**Value Codes and Amounts**	Enter code(s) and amount(s). See UB-92 Manual for list. Following codes required on Medicare/TPL claims. A1 Medicare Part A Deductible B1 Medicare Part B Deductible C1 Third Party Payer Deductible A2 Medicare Part A Coinsurance B2 Medicare Part B Coinsurance C2 Third Party Payer Coinsurance
42.	**Revenue Code**	Refer to UB-92 Manual for revenue codes and abbreviations. Accommodation days should not be billed on outpatient bill types. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes.
43.	**Revenue Code Description**	Refer to the UB-92 Manual for description of revenue codes.
44.	**HCPCS/Rates**	Enter accommodation rate for inpatient bills and HCPCS code for all applicable ancillary services on outpatient bills HCPCS codes are required for certain outpatient revenue codes.
45.*	**Service Date**	Enter date of service if different than From - Through date.
46.	**Service Units**	If accommodation days are billed, number of units billed

Field	Name/Status	Instructions
		must be consistent with patient status field (Field 22) and statement covers period (Field 6). If patient has been discharged, DES/DDD covers admission date to, but not including, discharge date. Accommodation days reported must reflect this. If patient expired or has not been discharged, DES/DDD covers admission date through last date billed.
47.	**Total Charges By Revenue Code**	Total charges obtained by multiplying units of service by unit charge for each revenue code. Each line other than sum of all charges may include charges up to $999,999.99.
48.*	**Non-covered Charges**	Enter any charges which are not payable by DES/DDD. Last entry in Field 48 is total non-covered charges, represented by revenue code 001.
49.	Unassigned	Not required.
50.* (A-C)	**Payer**	Enter name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by recipient and from which provider might expect some reimbursement. DES/DDD should be last entry.
51. (A-C)	**Provider No.**	Enter ID number assigned to provider by payer listed in Field 50 A, B, and/or C. AHCCCS Provider ID should be listed last.
52. (A-C)	Release of Information	Enter "Y" if provider has signed, written consent from recipient to release medical/billing information. Otherwise, enter "R" for restricted (or modified) release or "N" for no release.
53. (A-C)	Assignment of Benefits	Not required.
54.* (A-C)	**Prior Payments**	Enter amount received from any payer other than DES/DDD, including patient, listed in Field 50. If no payment was received as a result of billing, enter "0". (The "0" indicates that a reasonable attempt was made to determine available coverage for services provided. Enter only actual payments received. Do not enter any amounts expected from DES/DDD.)
55. (A-C)	Amount due	Not required.

Field	Name/Status	Instructions
56.	Unassigned	Not required.
57.	Unassigned	Not required.
58. (A-C)	**Insured's Name**	Enter name of insured covered by payer in Field 50.
59. (A-C)	**Patient's Relationship to Insured**	Enter relationship of recipient to insured.
60. (A-C)	**Patient CERT.# SSN-HIC**	Enter patient identification number related to payer in Field 50. Recipient's HCS ID must be listed last. If there is any uncertainty regarding the HCS ID, call DES/DDD Member Services.
61. (A-C)	**Group Name**	Enter insured's group name or "FFS" for AHCCCS or ALTCS recipients not enrolled in a plan.
62. (A-C)	Insurance Group Number	Leave blank for Fee-For-Service recipients.
63. (A-C)	Treatment Authorization	The PA number may be entered in this field. The DES/DDD system will search PA files to locate and associate valid PA with the claim.
64. (A-C)	Employment Status Code	Enter code for employment status of individual referenced in Field 58. See UB-92 Manual for codes.
65. (A-C)	Employer Name	Enter name of insured's employer.
66. (A-C)	Employer Location	Enter location of insured's employer.
67.	**Principal Diagnosis**	Enter principal ICD-9 diagnosis code. (Code should match diagnosis code listed on DES/DDD Prior Authorization if obtained.)
68.-75.	Other Diagnoses	Enter other applicable ICD-9 diagnoses codes for all inpatient stays and outpatient visits. Include codes for other conditions which existed during episode of care but were not primarily responsible for admission.

Field	Name/Status	Instructions
76.	**Admitting Diagnosis**	Required for inpatient bills. Enter ICD-9 diagnosis code that represents significant admitting diagnosis.
77.	E-Codes	Enter trauma diagnosis code, if applicable.
78.	DRG	Not required.
79.	**Procedure Method**	Enter "9" to indicate ICD-9 procedure codes.
80.*	**Principal Procedure Code and Dates**	Enter principal procedure code and date principal procedure was performed during inpatient stay or outpatient visit. ICD-9-CM procedure codes are required. If more than one procedure is performed, principal procedure should be one related to primary diagnosis, performed for definitive treatment of that condition and which requires highest skill level.
81.	Other Procedure Codes	Enter other procedure codes in descending order of importance.
82.	**Attending Physician**	Enter AHCCCS ID number of attending physician. Required for inpatient claims, and if applicable, for outpatient claims.
83.	Other Physician	Enter AHCCCS ID of any other assisting physician.
84.*	**Remarks**	Required on adjustments, resubmissions and voids. Enter the CRN of claim being adjusted, resubmitted or voided. For resubmission of denied claims, write "Resubmission" in this field.
85.	**Provider Representative**	An authorized representative must sign each claim form verifying the certification statement on reverse of claim. Rubber stamp or facsimile signatures are acceptable but must be initialed by a provider representative.
86.	**Date**	Enter date bill is submitted in MM/DD/YY format.

CMS 1500 Claim Form Instructions

The following instructions apply for completing the CMS 1500 claim form.

Note: All **bold type** fields are required by DES/DDD. Failure to complete these fields may cause the claim to be denied. An asterisk (*) next to the number of a bold (required) field indicates required if applicable.

Field	Name/Status	Instructions
1.	**Program Block**	Check second box labeled "Medicaid".
1a.	**Insured's ID Number**	Enter recipient's HCS ID number. If there are questions about eligibility of the HCS ID number, call DES/DDD Member Services.
2.	**Patient Name**	Enter recipient's last name, first name, and middle initial as they appear on the HCS ID card.
3.	**Patient Birth Date**	Enter recipient's date of birth.
	Patient's Sex	Check appropriate box.
4.	Insured's Name	Enter "Same" to indicate that insured and recipient name in Field 2 are same.
5.	Patient Address	Enter recipient's address as street, city, state, and zip code. Enter area code and telephone number.
6.	Patient Relation to Insured	Not required.
7.	Insured Address	Not required.
8.	Patient Status	Check boxes that represent recipient's marital status, employment, and student status.
9.*	**Other Insured's Name**	If recipient has no coverage other than ALTCS, leave blank. If other coverage exists, such as private insurance, enter name of insured. If other insured is recipient, enter "same" to indicate that other insured's name is the same as recipient.
9a.*	**Other Insured's Group Number**	Enter group number of other insurance.

Field	Name/Status	Instructions
9b.	Other Insured's DOB/Sex	If the other insured is not the ALTCS recipient, complete this block.
9c.	Other Insured's Employer/School	Enter name of organization through which insurance is obtained, such as employer of insured or school that makes insurance available.
9d.*	**Insurance Plan or Program Name**	Enter name of insurance company or program name that provides the insurance coverage.
10. (A-C)	Relation of Patient Condition	Check appropriate box to indicate if recipient's condition is result of employment, auto accident, or other type of accident.
11.	Insured's Group Policy or FECA #	If recipient is a newborn, enter mother's HCS ID number.
11a.	Insured's DOB/Sex	Not required.
11b.	Employer's Name or School Name	Not required.
11c.	Insurance Plan Name or Program Name	Not required.
11d.*	**Other Health Benefit**	Check appropriate box to indicate other health benefit.
12.	Patient or Authorized Person's Signature	Recipient's signature will authorize release of medical or treatment data.
13.	Insured's/Authorized Person's Signature	Not required.
14.	**Date of Illness or Injury**	Enter date of onset of symptoms or date of injury, if available.
15.	Date of Same or Similar Illness	Not required.
16.	Dates Patient Unable to Work in Current Occupation	Not required.

Field	Name/Status	Instructions
17.*	**Name of Referring Physician**	If recipient was referred or service was ordered by another physician, enter name of referring physician. If the service billed was not a referral, enter "0". (Required only for podiatry services.)
18.	Hospitalization Dates	For hospitalized recipients, enter From and Through dates of hospitalization related to service billed on this claim.
19.	Reserved for Local Use	Not required.
20.	Outside Lab	Check appropriate box to indicate whether outside lab work was performed as part of service. If "Yes" is checked, enter charge for these services.
21.	**Diagnosis Codes**	Enter up to four ICD-9 diagnosis codes appropriate to recipient's condition. Only ICD-9 codes will be accepted. Written description is optional.
22.*	**Medicaid Resubmission Code**	Enter appropriate code to indicate whether claim is an adjustment or void of paid claim or resubmission of denied claim: A Adjustment of paid claim V Void of paid claim R Resubmission of denied claim. For adjustments, enter "A". All claim lines must be submitted for reprocessing. Make changes to appropriate lines and submit entire claim for reprocessing. Do not blank out any lines. If any lines are blanked out, system will assume that line should not be considered for reimbursement and will recoup that line when the claim is reprocessed. For voids, enter "V". Submit only those claim lines to be voided. For resubmissions, enter "R". All claim lines must be submitted for reprocessing. Make necessary changes to appropriate lines and submit entire claim for reprocessing. Do not blank out any lines of the 1500. If any lines are blanked out, the system will assume that those lines should not be considered for reimbursement.

Field	Name/Status	Instructions
		Claims to be voided or adjusted must have been paid by DES/DDD. Claim resubmissions must have been denied by DES/DDD.
23.	Prior Authorization Number	The DES/DDD claims system will search for a valid prior authorization for the claim. Providers must still request PA, as appropriate, from the HCS PA Unit. The claim must match the PA number assigned by the HCS PA Unit.
24A.	**Date of Service**	Enter beginning and ending service dates as MM/DD/YY. If service was completed in one day, dates will be the same. From date must be equal to or prior to the To date. To date must be equal to or prior to billing date (Field 31).
24B.	**Place of Service**	Enter the code that describes the place of service: 11 Office 12 Patient's residence 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room - hospital 24 Ambulatory surgical center 25 Birthing Center 26 Military treatment facility 31 Skilled nursing facility 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance - land 42 Ambulance - air or water 51 Inpatient psychiatric facility 52 Psychiatric facility partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded (ICF/MR) 55 Residential substance abuse treatment facility 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End stage renal disease treatment facility 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility Note: Non-emergency transportation providers should use "99".

Field	Name/Status	Instructions
24C.	Type of Service	Not required.
24D.	**Procedure**	Enter HCPCS/CPT procedure code that identifies the service provided.
	***Procedure Modifier**	Enter procedure modifier if appropriate.
24E.	**Diagnosis**	Relate service provided to diagnosis in Field 21 by entering number of diagnosis. Enter only reference to Field 21 (1-4), not diagnosis code itself. If more than one number is entered, they should be in descending order of importance.
24F.	**Charges**	Enter total charges for each procedure. If more than one unit of service was provided, enter charges for all units. For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.
24G.	**Units**	Enter units of service provided during dates in Field 24A. Unit definitions must be consistent with HCPCS Manual. Bill all units of service delivered on given date on one line.
24H.	EPSDT/ Family Planning	If the service billed on this line is an EPSDT service, result of an EPSDT referral, or a family planning service, enter the appropriate code in this field.
24I.	**Emergency**	Mark this box if service was an emergency service, regardless of where it was provided. Indicate emergency on each line applicable. Documentation attached to the claim to substantiate the emergent nature of the service will not be reviewed if service is not indicated as an emergency.
24J.*	**COB**	Check this box for coordination of benefits if there is Medicare or other TPL for services billed on this line.
24K*.	**Reserved for Local Use**	Field is used to report benefits for recipients with Medicare and/or other insurance. Enter Medicare Coinsurance and Deductible amounts. First amount will always be considered Coinsurance and second amount will be treated as Deductible. If there is no Deductible, enter Coinsurance amount/zero (Example: $20/0). For recipients and services covered by third party payer, enter amount paid. Attach EOB.

Field	Name/Status	Instructions
25.	**Federal Tax ID**	Required.
26.	Patient's Account Number	Enter any number as a patient account number that identifies this claim uniquely. DES/DDD will report this number on the remittance advice, providing a cross reference between DES/DDD CRN and provider's own accounting or tracking system.
27.	Accept Assignment	Not required.
28.	**Total Charges**	Enter total for all charges for all lines on claim.
29.*	**Amount Paid**	Enter total amount provider has been paid for claim by all sources other than DES/DDD. Do not enter any amounts expected to be paid by DES/DDD.
30.	Balance Due	Enter balance due by subtracting sum of payments in Field 29 from total charges.
31.	**Signature**	Claim must be signed by provider or authorized representative. Rubber stamp signatures are acceptable if initialed by provider representative.
	Date	Enter date on which claim was signed.
32.	**Name and Address of Facility Where Services Were Rendered**	Required.
33.	**Provider Name, Address and Phone**	Enter name, address, and telephone number of provider rendering service. If a group is billing, enter group biller's name, address and telephone number.
	ID Number	Enter service provider's six-digit AHCCCS provider ID number and two-digit locator code next to the "PIN#". Do not enter more than two digits for locator code.
	***Group ID**	If the service provider is part of a group recognized by AHCCCS and wishes payment to be made to the group, the group ID number should be entered in "GRP#" field.

ADA Form Instructions

The ADA 2002 claim form is the only form that DES/DDD will accept for billing dental services provided on or after January 1, 2004.

The following instructions apply for completing the ADA claim form:

Note: All **bold type** fields are required by DES/DDD. Failure to complete these fields may cause the claim to be denied. An asterisk (*) next to the number of a bold (required) field indicates required if applicable.

Field	Name/Status	Instructions
1.	**Type of Transaction**	Not required.
2.*	**Predetermination/ Preauthorization Number**	Enter appropriate code ("A" or "V" to indicate if claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the DDD Claim Reference Number (CRN) of the denied claim being submitted or paid claim being adjusted or voided in the Field labeled "Original Reference No."
3.*	**Primary Payer Name and Address**	Required if applicable.
4.	Other Dental or Medical Coverage	Check appropriate box to indicate whether member has third party coverage
5.	Subscriber name	Required if applicable.
6.	Date of Birth	Required if applicable.
7.	Gender	Required if applicable.
8.	Subscriber Identifier	Required if applicable.
9.	Plan/Group Number	Required if applicable.
10.	Relationship to Primary Subscriber	Required if applicable.
11.	Other Carrier Name, Address	Required if applicable.
12.	Primary Subscriber Name and Address	Enter the member's last name, first name and middle initial.
13.	Date of Birth	Enter member's date of birth.

Field	Name/Status	Instructions
14.	Gender	Check appropriate box indicating members' gender.
15.	Subscriber Identifier	Enter member's AHCCCS ID number. Contact the 24/7 800 number listed in "Contacting Us" if there are questions regarding eligibility or the AHCCCS ID number.
16.	Plan/Group Number	Not required.
17.	Employer Name	Not required.
18.	Relationship to Primary Subscriber	Not required.
19.	Student Status	Not required.
20.	Name	Not required.
21.	Date of Birth	Not required.
22.	Gender	Not required.
23.	Patient ID/ Account Number	This is your number, assigned to identify this claim in your records. This number will provide a cross-reference between the DES/DDD CRN and your own accounting or tracking system.
24.	Procedure date	Enter the procedure date in MM/DD/YYYY format.
25.	Area of Oral Cavity	Enter the code for the area of the oral cavity. Consult ANSI/ADA/ISO Specification No. 3950 *Designation System for Teeth and Areas of the Oral Cavity* for codes.
26.	Tooth System	Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation system. Enter "JO" when using ANSI/ADA/ISO Specification No. 3950.
27.	Tooth Number (s) or Letter (s)	Enter the tooth number when the procedure directly involves a tooth. Use commas to separate individual tooth numbers. If a range of teeth is involved, use a hyphen to separate the first and last tooth in the range.
28.	Tooth Surface	Designate tooth surface(s) when the procedure directly involves one or more tooth surfaces.
29.	Procedure Code	Enter the appropriate procedure code from the CDT-4 Manual.

Field	Name/Status	Instructions
30.	Description	Enter the description of the procedure code billed in Field 29.
31.	Fee	Enter the fee for the procedure code billed in Field 29.
32.	Other Fees	Not required.
33.	Total Fee	Enter the total of all fees in Field 31.
34.	Missing Teeth	Mark all missing teeth.
35.	Remarks	Not required.
36.	Parent/Guardian Signature and Date	Not required.
37.	Subscriber Signature And Date	Not required.
38.	Place of Treatment	Check the appropriate box.
39.	Number of Enclosures	Required if applicable.
40.	Is Treatment for Orthodontics?	Required if applicable.
41.	Date Appliance Placed	Required if applicable.
42.	Months of Treatment	Required if applicable.
43.	Replacement of Prosthesis	Check the appropriate box. If "Yes" is checked, complete Field 44.
44.	Date of Prior Placement	Required if applicable; If "Yes" is checked in Field 43, enter the date of prior placement in MM/DD/YYYY format.
45.	Treatment Resulting	Required if applicable; Check the appropriate box, as applicable.
46.	Date of Accident	Required if applicable; Enter the date in MM/DD/YYYY format.
47.	Auto Accident State	Required if applicable; Enter the name of the state where the accident occurred.

Field	Name/Status	Instructions
48.	Billing Dentist/ Dental Entity Name And Address	Enter the name and address of the billing dentist or dental entity.
49.	Provider ID (Group)	Enter the AHCCCS provider ID of the billing dentist or dental entity.
50.	License Number	Enter the license number of the billing dentist or dental entity.
51.	SSN or TIN	Enter the Social Security Number or tax ID number of the billing dentist or dental entity.
52.	Phone Number	Not required.
53.	Signature of Treating Dentist	The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.
54.	Provider ID (Group)	Enter the AHCCCS provider ID of the treating dentist.
55.	License Number	Enter the license number of the treating dentist.
56.	Address (Treating Dentist)	Not required.
57.	Phone Number (Treating Dentist)	Not required.
58.	Treating Provider Specialty	Not required.

Universal Pharmacy Claim Form Instructions

The Universal Pharmacy claim form is the only form that DES/DDD will accept for billing pharmacy items that are not an integral part of a hospitalization.

The following instructions apply for completing the Universal Pharmacy Form:

Note: All **bold type** fields are required by DES/DDD. Failure to complete these fields may cause the claim to be denied. An asterisk (*) next to the number of a bold (required) field indicates required if applicable.

Field	Name/Status	Instructions
1.	Group Number	Not required.

Field	Name/Status	Instructions
2.	**Card Holder ID**	Enter nine-digit AHCCCS ID of recipient for whom the prescription was written.
3.	**Card Holder Name**	Enter name of recipient for whom prescription was written.
4.	**Other Third Party Coverage**	Check appropriate box to indicate whether recipient has third party coverage.
5.	**Patient Information**	Enter recipient's last name, first name, and middle initial; date of birth, if available; sex; and relationship to the cardholder.
6.	**Pharmacy Information**	Enter name, street number, city, state and zip code of provider who filled prescription
7.	**Pharmacy Number**	Enter six-digit AHCCCS provider ID number and two-digit locator code assigned.
8.	Phone	Enter phone number, including area code, of pharmacy that filled prescription
9.	**Date Rx Was Written**	Enter date of prescription as MM/DD/YY.
10.	**Date Rx Was Filled**	Enter date of service for this billing. If prescription is a refill, date of refill should be entered.
11.	**Rx Number**	Enter the prescription number. This will serve as a cross reference with the DES/DDD CRN. Correspondence from DES/DDD regarding the claim will reference this number.
12.	**New or Refill**	Enter "N" if claim is new, "R" if it is a refill.
13.	**Metric Quantity**	Enter quantity provided. If form is tablets or capsules, number should be number of pills dispensed.
14.	**Days Supply**	Enter number of days prescription is expected to cover.
15.	**National Drug Code**	Enter labeler number, the product number, and package number for the items dispensed. All 11 digits must be entered on claim form. If there are leading zeros in NDC code, they must be entered.

Example:

Labeler No.	Product No.	Pkg.
0000	1234	567

Field	Name/Status	Instructions
16.	Prescriber Indent.	Enter AHCCCS provider ID of the prescribing physician, if the number is available.
17.	**DAW**	Indicate whether prescribing provider required a brand name drug by entering "1". If generic items were allowed, enter "0".
18.	**Ingredient Costs**	Enter cost of ingredients of dispensed items to pharmacy.
19.	Dispensing Fee	Not required. Dispensing fee systematically added by DES/DDD system.
20.	Tax	Do not enter sales tax amounts. DES/DDD is exempt from payment of sales tax.
21.	**Total Price**	Enter sum of components' cost (not including dispensing fee).
22.*	**Deductible Amount**	Enter amount of any third party payments received. If third party payer was billed and claim was denied or no payment resulted, enter "0". The "0" indicates that a reasonable attempt was made to determine available coverage and collect for service provided.
23.	Balance	Enter amount due from DES/DDD (not including dispensing fee).
24.	**Authorized Pharmacy Representative**	Authorized representative of pharmacy must sign and date claim. Rubber stamp signatures acceptable but must be initialed by a provider representative.

Remittance Advice

Reimbursement checks are accompanied by a remittance advice (remit). The remit identifies the provider and provider ID number, the type of claim submitted (UB-92, CMS 1500, ADA, Universal C Form), the date of the check run, the member name, ID number, and patient account code (if the provider supplied this code on the claim form), the services claimed and dates of service, and DES/DDD's adjudication results. DES/DDD may pay, pend, or deny a claim.

Providers who disagree with the DES/DDD adjudication results may file a written request for review within 35 days of the date of the remit. Send this request for review to:

DES/DDD Business Operations
1789 W. Jefferson, Site Code 791A
P.O. Box 6123
Phoenix, Arizona 85005

Providers who have questions about the remit may call DES/DDD Business Operations during normal working hours at 542-6874.

How to Read a Remittance Advice

The remit fields are described below:

1.	Provider ID number	The AHCCCS Provider Registration Number
2.	Provider Name, Address	If the provider is listed as a member of a group, the group name and address will appear here. If the provider bills as an individual, the provider's name and address will appear here.
3.	Type of Claim	Either UB-92 or CMS 1500 or Pharmacy Claim will appear here, depending on the provider claim submission type.
4.	Remit Date:	The date the remittance advice report was run. Checks are mailed within 2 business days of this date. Provider requests for review are timed from this date.
5.	Remit Headings	Revenue Code means the revenue code submitted on the claim. The remit will list each revenue code in descending order, with associated amounts. Amount billed means the amount the provider billed. Not Allowed means the amount DES/DDD will not pay because it is over the CFFS amount.

		Allowed amount means the billed amount minus the not allowed amount. Other insurance means the amount paid by other insurance. Co-pay amount means the amount the member is responsible to pay as a co-payment. Discount/Interest means the amount DES/DDD can deduct from the payable amount due to AHCCCS rule or the amount of interest DES/DDD must pay for late payment according to AHCCCS rule. Amount paid means the amount DES/DDD paid on this claim on this remit. Remarks identifies the reason(s) for DES/DDD adjudication. Remarks apply to the revenue code/claim line identified.
6.	Member name, ID number	Member identifying information supplied on claim. rate code, and patient account number (if supplied by the provider)
7.	CRN #	Claim Reference Number assigned to the claim by DES/DDD.
8.	Date(s) of service	Date(s) of service on the claim.

The second page of the remit totals all revenue codes/claim lines into payment categories for the fiscal year. Payment category definitions are:

Amount billed	The amount billed on the provider claim
Not allowed	The amount DES/DDD cannot pay due to AHCCCS CFFS rule
Allowed amount	The amount billed minus the amount not allowed.
Other insurance	The amount paid by other insurance
Co-Payment	The amount due from the member
A - Advance Payment	The amount of any advance payments made to the provider by DES/DDD

B - Bonus	The amount of bonus payments made according to contract terms by DES/DDD
D - Discount/Interest	The amount of discount taken or interest applied according to AHCCCS rule
W - Withhold	The amount from the claim(s) that DES/DDD has withheld from provider payments according to contract terms
Amount Paid	The total amount paid to the provider by DES/DDD during the fiscal year.

Page 3 of the remit details provider total payments by payment categories as above.

Page 4 of the remit details provider total payments by claim type (i.e., out-patient, in-patient, or Rx-DME) by payment categories by fiscal year.

Medical Claims Review

The Division uses the following standards to determine whether claims are sent through Medical Review:

- All hospital outlier claims
- All anesthesia claims
- All emergency department claims over $2500

Common Billing Errors

To avoid delay or non-payment of your claim, be sure all required claim information is correct and included on the claim form. Some common billing errors can be avoided.

- Billing across months will delay payment. Split bill when services span the beginning and ending of two months.
- The member's or provider's AHCCCS ID number is missing or invalid.
- The member is ineligible on the DOS.
- The member has other insurance that must be billed first (submit the EOB with the claim).
- The provider is not registered with AHCCCS, or the registration has expired. Call AHCCCS Provider Relations at (602) 417-7670, option #5. The in-state toll free number is 1-800-654-8713. The out-of-state toll free number is 1-800-523-0231.
- The provider is not registered with AHCCCS for the category of service provided. .

Call AHCCCS Provider Relations at (602) 417-7670, option #5. The in-state toll free number is 1-800-794-6862. The out-of-state toll free number is 1-800-523-0231.

- The claim was filed after the filing due date.
- The diagnosis or procedure code(s) is/are invalid.
- The PA number does not belong to the service claimed or was not given by DES/DDD.
- The billing provider is not the provider that was given the PA number.
- The PA number does not belong to the member listed on the claim.
- The HCPCS code, bill type, and/or location code is/are missing or invalid.
- The claim is not legible.

Appeal Procedure

An integral part of the Division's Health Care System are the claim dispute and appeal procedures, which are used to resolve differences between members, providers and the Division.

- Provider Claim Disputes

All claim disputes by providers relating to an adverse decision or action by the Division shall be filed in writing with:

DES/Division of Developmental Disabilities
Office of Compliance and Review, Site Code 791A
1789 West Jefferson
Phoenix, Arizona 85007
(602) 542-6859

The Compliance and Review Unit shall review the claim dispute and provide a written decision within 30 calendar days of receipt of the claim dispute. If the provider is not satisfied with the response, a written request for a fair hearing must be filed with the Office of Compliance and Rewiew within 30 calendar days after the mailing date of the Notice of Decision.

- Member Appeals

Members who have problems or grievances (complaints) regarding health care services are urged to call their DDD Support Coordinator or the Health Care Services Unit Member Services staff. DDD staff will assist the member to resolve problems or grievances.

Members may appeal any adverse decision or action by calling or writing the Office of Compliance and Review at the above address/telephone number. DES/DDD Support Coordinators may also assist the member to appeal.

All providers, including primary care physicians, specialists and ancillary service providers, upon notification of a Member Appeal, shall assist the Office of Compliance and Review or its designee in researching the appeal.

Verbal or written information to document the issue shall be supplied within the specified time frames. This may include medical records of the member. Release of this information does not require a signed release form by the member pursuant to AHCCCS Rules and Regulations (R9-22-512F.).

All medically necessary health care may continue to be provided to the member during the appeal process, if requested by the member.

Responsibilities of Members or Their Responsible Persons

Members or their responsible person(s) should, with assistance from their DES/DDD Support Coordinator when necessary:

- Maintain their ALTCS eligibility by keeping eligibility redetermination appointments.
- Select a primary care physician (PCP) within ten (10) days of notification from DES/DDD.
- Coordinate all necessary covered medical services through their PCP.
- Notify the AHCCCSA eligibility worker and the Division's Support Coordinator of changes in demographic information (i.e. address, telephone number, etc.).
- Arrive timely for scheduled appointments or notify the provider in advance and reschedule.
- Provide all available information to the PCP regarding requested medical services, and cooperate in obtaining additional information requested by the PCP.
- Show their HCS Identification Card as proof of eligibility for covered services to all health care providers (e.g. dentists, medical specialists, hospitals, and emergency rooms.
- Provide DES/DDD and all health care providers with all information, including changes in private and public insurance, third party liability, financial assistance or other benefits received by the member.
- Pursue eligibility with Children's Rehabilitative Services (CRS) when referred by DES/DDD or their PCP.
- Direct any complaints or problems to DES/DDD Health Care Services, Member Services or Office of Compliance and Review at the earliest opportunity, and
- Adult members are encouraged to complete an advance directive and file it in their PCP's medical chart.
- Participate in family-centered treatment consultations at the request of their PCP, Support Coordinator, or other district Personnel.
- Pursue eligibility with a Regional Behavioral Health Authority (RBHA) when referred by DES/DDD or their PCP.

DES/DDD Support Coordinator Roles and Responsibilities

- Intake and assessment of member needs.
- Development and implementation of an Individual Support Plan (ISP), in consultation with the PCP as needed.
- Completion of an Inventory for Client and Agency Planning (ICAP) assessment, sharing pertinent information with the PCP as appropriate.
- Coordination of services with the family and all involved persons and providers, including the PCP, to meet individual needs.
- Monitoring and periodic review of the ISP, in consultation with the PCP as needed.
- Assisting members in removing barriers to service. This may include coordination with the PCP.
- Providing closure of the ISP, and
- Assisting members and their responsible persons in meeting their responsibilities.

The PCP serves as the gatekeeper for all medical services and should facilitate the member receiving necessary services in a timely fashion. The Support Coordinator is not responsible for making medical decisions, however, can often be a valuable resource to the PCP in gathering background information about the member. It is imperative that the gatekeeper of long term care services (the Division's Support Coordinator) and the gatekeeper of medical services (the PCP) closely coordinate their efforts.

Responsibilities of the PCP

The PCP is the gatekeeper for all medical services obtained by the DD/ALTCS member. The primary purpose of this role is to assure that a single qualified professional coordinates and manages the member's medical needs. Additionally, DES/DDD expects the PCP to:

- Maintain a collegial working relationship with DES/DDD personnel in order to become familiar with the guiding values for serving persons with developmental disabilities.
- Meet all applicable Americans with Disabilities Act (ADA) requirements when providing services to members who may request special accommodations such as interpreter/translation services, assistance with physical accessibility or alternative formats.
- Deliver and/or arrange for timely, high quality, cost-effective medical and dental services consistent with accepted professional standards, understanding that it may take more time and care for the diagnosis and treatment of a person with chronic diseases and disabilities and interaction with his/her family.
- Manage the member's care to ensure continuity of care.
- Participate in the ISP process when PCP expertise is needed to ensure most appropriate placement and plan of care.
- Review the ISP submitted by the DES/DDD Support Coordinator to become familiar with the member's needs and requirements.
- Maintain the medical record for the member.
- Evaluate the member and refer to Children's Rehabilitative Services (CRS) when appropriate. Follow through on referrals made to CRS. (See Appendix F for the CRS referral form.)
- Evaluate the member and refer to a local Regional Behavioral Health Authority (RBHA) when appropriate. Follow through on referrals made to the RBHA. (See Appendix F for the RBHA referral form.)
- Discuss advance directive options with an adult member and keep on file any completed advance directive.

Prior Authorization (PA)

Examinations, routine procedures and treatments provided in a PCP's office may be performed without prior authorization. Medical laboratory tests performed in the provider's office must meet CLIA regulations. A consultation only visit conducted by a

specialty physician also does not require prior authorization. However, for any providers, including specialty providers, to receive reimbursement for billing codes other than CPT Evaluation and Management, prior authorization must be obtained from the Health Care Services Prior Authorization Unit. The following inpatient and ancillary services also require PA:

- Physician treatment
- Medical laboratory tests paid at more than $1,000 according to the CFFS.
- X-ray and other diagnostic imaging procedures paid at more than $1,000 according to the CFFS.
- Hospitalization
- Durable medical equipment paid at more than $100 according to the CFFS.
- Outpatient surgery
- Medical supplies paid at more than $100 according to the CFFS.
- Emergency dental services for members aged 21 years and older
- Medically necessary transportation for covered medical services
- Orthotics and Prosthetics over $100 per item

Check the list of Covered Services in this Manual for more specifics.

Prior authorization can be obtained by calling:

(602)238-9028	Monday through Friday (excluding holidays) between 8:00 am and 5:00 pm
	or
1-800-624-4964	24 hours per days / 7 days per week.

Prior authorization may also be faxed to:

1-602-253-9083	Faxed requests for PA will be responded to within 2 working days of receipt. (See Appendix C: PA Fax Form)

Prior authorization for the services listed above can also be obtained through the US mail by sending a completed PA Fax Form requesting covered services to:

Prior Authorization Unit
DES/Division of Developmental Disabilities
2200 N. Central Avenue, Suite 506
Phoenix, Arizona 85004

Regardless of the transmittal mode of the PA request, the PA nurse may request additional information to document the medical necessity of the request. The PA nurse may call, fax, or write to the provider to request needed information.

Authorizations requested by phone that can be approved at the time of the call will be given a verbal PA number. No paper will be sent in follow up. Authorizations requested by fax or mail may be approved by phone, fax, or mail.

If an authorization is denied, the requesting provider is called and sent notice by mail with an explanation for the denial. The PCP may grieve the denial of a referral by following the steps outlined in Appeal Procedures section of this handbook.

Concurrent Review

The Health Care Services Unit (HCS) coordinates acute care concurrent review activities for DD/ALTCS members who are not enrolled in a contracted health plan or who are enrolled with Indian Health Services (IHS) and are admitted to a non-IHS facility. Concurrent review, as performed by DES/DDD, is the process of continual reassessment of the medical necessity and appropriateness of acute inpatient care during a stay in a hospital, nursing facility, other sub-acute facility in order to justify the continued inpatient stay.

Upon admission, HCS's Utilization Review Nurses either review documentation on-site or conduct a telephonic review to verify the appropriateness of continued placement and service need. For individuals who are admitted to an acute care facility for an extended period of time, HCS's Nurses perform concurrent review either on-site or telephonically for the purpose of discharge planning coordination with the appropriate inpatient facility staff.

The Division is involved in concurrent review of service need and appropriateness of placement for other than acute care. HCS coordinates the continued assessment of the need for skilled nursing services in the home and community based population. HCS, through the Ventilator Nurse and Case Management Team, also performs concurrent review for all services, including inpatient stays, for persons who are ventilator dependent. HCS, through the PASRR Coordinator, complies with federal PASRR regulations for services and placements in nursing facilities for persons with mental retardation.

As needed, District and HCS Nurses may consult with the DDD Medical Services Manager, the DES/DDD Medical Director, or the attending physician in order to develop the most appropriate plan of care for the patient.

Medical Records

The medical record is maintained by the PCP and shall include a written record of all medical services received by the member.

The medical record should include written documentation of:

- Inpatient, outpatient and emergency care

- Specialist care
- Ancillary care
- Laboratory, radiological and medical imaging tests and findings
- Prescriptions for medications and /or treatment
- Inpatient discharge summaries and histories, and
- Physicals, including a list of smoking and chemical dependencies.

Medical records are to be maintained in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective medical review and medical audit processes and which facilitates an adequate system for follow up treatment.

Medical records must be legible, signed and dated. Confidentiality of medical records must be maintained.

Written consent of the member or responsible person must be obtained before medical records may be transmitted to any other physician except other Division contractors and Division staff. DDD Support Coordinators do not require written consent of the member or responsible person in order to view or take copies of the member's medical record.

Medical records or copies of medical records written by referred physicians, practitioners, dentists or others must be forwarded to the PCP within ten (10) working days of delivery of service.

The Division's Support Coordinators are required to track and summarize the member's medical circumstances and, therefore, may at times request information from, or the opportunity to review, the medical records. Signed release from the patient is not required for Support Coordinator review of the record.

The Division performs quality management and utilization review and, as a result, reserves the right to request medical records and other information as required to perform these functions. Your office will be called in advance to arrange an appointment convenient to you to review medical records.

Appointment Procedures

AHCCCS appointment standards require that members obtain appointments the same day for emergency or urgent care and within two (2) to three (3) weeks for routine care. Referral appointments to specialists must be the same day for emergency or urgent care and within thirty (30) days for routine care. The AHCCCS office wait time standard requires that members wait no more than 45 minutes for a scheduled appointment with a primary care provider or specialist, unless the provider is unavailable due to an emergency. Providers are expected to adhere to the AHCCCS appointment and office wait time standards. HCS may review the provider's office practices for compliance with

the AHCCCS appointment and office wait time standards.

Difficult Member Arrangements

Difficult members who repeatedly violate ALTCS Rules will be accommodated. The Division does not consider an individual's abuse of emergency rooms, services or ALTCS guidelines as grounds for refusal of care. Contact Member Services at (602) 238-9028 or 1-800-624-4964 for HCS assistance with problems associated with individual members.

Emergency Care

The most cost-effective location for the delivery of most acute care services is the primary care physician's office. However, there are occasions when a member requires the services available in the urgent care unit or hospital emergency department.

The PCP must provide instructions to assigned members for accessing appropriate care, including the use of 911 and the emergency department, anytime they believe they have a life/limb threatening emergency. The provider shall not refer members to emergency rooms for non-emergent care. Remember, all providers must be AHCCCS registered and bill with an AHCCCS Provider ID number to be reimbursed by DES/DDD.

Advance Directives

An advance directive is a written (or oral) statement about a member's choices for medical treatment if s/he loses the ability to make decisions. Federal regulations require certain providers to notify adult members about their right to have an advance directive. A parent or guardian of an individual under the age of 18 years may have a written health care directive for that minor.

PCPs are encouraged to ask members to complete an advance directive and file it in the member's medical record. The member's medical record must note if s/he has an advance directive.

An advance directive may be in the form of a prehospital medical care directive (sample copy is in Appendix D); a living will; and/or a written health care power of attorney.

- A prehospital medical care directive allows an individual to direct the withholding of specific care by emergency medical and hospital personnel. Per statute, this directive is printed on an orange background and is either letter or wallet size.

- A living will is a written statement which directs and controls the health care treatment decisions that can be made on an individual's behalf. A person may use a living will without a health care power of attorney or may attach a living will to his/her health care power of attorney. If the living will is not part of a health care power of attorney, it must be witnessed and notarized.

- A health care power of attorney permits an adult to designate another adult

individual(s) to make health care decisions on his/her behalf whenever the individual is unable to communicate his/her wishes. This designation must be made when the individual is of sound mind and free from duress; further, the designation must be in writing, signed, witnessed and notarized in order to be valid in Arizona. A prehospital medical care directive, a health care directive, a living will and/or a written health care power of attorney virtually replace what was generally referred to as a Do Not Resuscitate (DNR) order; however, an individual's primary care physician must also note a DNR order on the individual's medical chart.

A health care provider with moral objections to a health care directive is obliged to cooperate with the directive or promptly transfer the responsibility for the individual's care to a provider who is willing to act in accordance with the directive.

A.R.S. 36-3202, et seq., DES/DDD Policy 1504.

Fraud and Abuse

Providers are responsible to report suspected provider or member fraud and abuse. The A.R.S. and Code of Federal Regulations (CFR) provide the following definitions regarding fraud and abuse:

- Abuse (by member) means intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault (A.R.S. 46-451).

- Abuse (by provider) means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in any unnecessary cost to the Medicaid (AHCCCS) program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care (42 CFR 455.2).

- Exploitation means the illegal or improper use of an incapacitated or vulnerable person or his resources for another's profit or advantage (A.R.S. 46-451).

- Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2).

Reporting of suspected fraud or abuse is confidential, to the degree permitted by law or allowed under AHCCCS rule. If you suspect that a provider is submitting inappropriate/inaccurate claims or rendering medical care that results in unnecessary cost to the AHCCCS/ALTCS program; or if you suspect that a member has misrepresented any facts to obtain eligibility, given his/her HCS card to another individual to obtain services, or if you have any information or for any reason suspect that a member is abusing services, you must call your Provider Relations Representative.

If a member knowingly withholds information that identifies him/her as a DD/ALTCS

member, which does not allow the provider the opportunity to obtain needed prior authorization from DES/DDD, the provider may bill the member for services denied payment by DES/DDD (A.A.C. R9-22-702 C).

Cultural Competency

DES/DDD supports the philosophy that consideration of a member's needs, preferences and culture can result in increased member satisfaction and can lead to improved health outcomes. A member's culture can have a direct impact on how members access medical care and how they respond to medical treatment.

As part of DES/DDD's cultural competence program, DES/DDD provides interpreter services at no cost to fee-for-service providers (see the "Interpreter Services" section of this manual). For more detailed information on cultural competence DES/DDD encourages you to review "Culturally Competent Patient Care: A Guide for Providers and Their Staff" located in Appendix I of this manual.

Covered Services and PA Requirements

Covered Services provided to DD/ALTCS members must be medically necessary and provided by, or under the direction of a PCP, dentist, or specialist under the referral of a PCP. Nurse practitioners and physician assistants may provide covered services in appropriate affiliation with a PCP. Delegation for the provision of primary care services to a practitioner shall not diminish the responsibility of the PCP.

Subject to the limitations and exclusions in AHCCCS and ALTCS Rules, the following services will be covered at a minimum:

- Inpatient and outpatient hospital. *CALL PRIOR AUTHORIZATION.*
- Ambulatory surgery. *CALL PRIOR AUTHORIZATION.*
- Nursing Facility (NF) when placed in such facility for short-term convalescent care in lieu of hospitalization. *CALL PRIOR AUTHORIZATION.*
- Emergency room, including out-of-area emergency services.
- Physician. *CALL PRIOR AUTHORIZATION IF SERVICES RENDERED ARE OTHER THAN CPT E & M.*
- Outpatient, including those AHCCCS covered services that may be provided in a rural health clinic or Federally Qualified Health Center.
- Health Risk Assessment and Screening for members age 21 and older. This screening includes a physical exam, screening tests for cancer (mammograms, colon-rectal exams), screening for hepatitis-B every two years, and immunizations for hepatitis-B, pneumococcus, diphtheria-tetanus, influenza, rubella, and measles.
- Practitioner visits to the member's home, or natural environment, when medically necessary for the member and in agreement with the family.
- Laboratory, x-ray and medical imaging. *CALL PRIOR AUTHORIZATION IF CHARGES ARE GREATER THAN $1,000.00.*
- DES/DDD contracts with Walgreens Health Initiative for pharmacy benefit management services. Prescription drugs according to the Walgreen's Health Initiative (WHI) formulary are covered. **The Formulary is** available at the WHI website at: www.walgreenshealth.com/common/pdf/PreferredMedicationListCategory2004.pdf
- Medical supplies and durable medical equipment (DME). *CALL PRIOR AUTHORIZATION IF CHARGES ARE GREATER THAN $100.00.*
- Adaptive aids (adaptive aids list in Appendix E). *CALL PRIOR AUTHORIZATION.*
- Emergency transportation. *NOTIFY PRIOR AUTHORIZATION WITHIN 10 DAYS OF TRANSPORT.*
- Medically necessary transportation to receive covered services (i.e., to physician appointments, to laboratory sites, to pharmacies). *CALL PRIOR AUTHORIZATION.*
- Family planning including: pregnancy screening, drugs, supplies, devices and surgical procedures provided to delay or prevent pregnancy, family planning related medical and laboratory exams including ultrasound studies, treatment

resulting from complications of contraceptive use including emergency treatment, natural family planning education, screening for sexually transmitted diseases, postcoital emergency oral contraception within 72 hours of unprotected sex. Sterilizations require *PRIOR AUTHORIZATION.* Elective sterilization by hysterectomy will not be approved. Patient/guardian must comply with federal requirements to sign federal sterilization consent forms.

- Medically necessary abortions, when the pregnancy would endanger the life of the mother if the fetus were carried to term, or if the pregnancy is a result of rape. *CALL PRIOR AUTHORIZATION.*
- Rehabilitation therapies (physical, occupational, audiologic, speech) prescribed by the attending physician for an acute condition. (**See Other Programs: Therapy** in this Provider Manual.) *CALL PRIOR AUTHORIZATION*
- Respiratory therapy is covered on an inpatient or outpatient basis when prescribed by the PCP or attending physician and medically necessary to restore or improve respiratory functioning. *CALL PRIOR AUTHORIZATION*
- Audiology services to identify and evaluate hearing loss for members age 21 and older. Rehabilitation of hearing loss through other than medical or surgical means (i.e. hearing aids) for members age 21 and older is covered only when the hearing loss is due to an accident or injury-related emergent condition. *CALL PRIOR AUTHORIZATION.*
- Podiatry services to include: bunionectomies, casting for the purpose of constructing or accommodating orthotics, medically necessary orthopedic shoes that are an integral part of a brace, and medically necessary routine foot care for members with a severe systemic disease which prohibits care by a nonprofessional person. *CALL PRIOR AUTHORIZATION.*
- Orthotics and Prosthetics which are essential to the rehabilitation of the member, including scoliosis jackets. *CALL PRIOR AUTHORIZATION.*
- Early and periodic screening, diagnosis and treatment services for members under the age of 21. These services include all medically necessary Title XIX services. (**See Other Programs: EPSDT** in this Provider Manual.)
- Organ transplants deemed medically necessary are limited to the following services: kidney, cornea, heart, lung, heart/lung, liver, autologous and allogeneic bone marrow with related chemotherapy or radiotherapy. *CALL PRIOR AUTHORIZATION.*
- Dialysis, supplies, diagnostic testing and medication when provided by Medicare-certified hospitals or Medicare-certified ESRD providers. *NOTIFY PRIOR AUTHORIZATION.*
- Emergency eye care for members age 21 years and older and eyeglasses and contact lenses as the sole prosthetic device after cataract extraction. *CALL PRIOR AUTHORIZATION.* (**See Other Programs: EPSDT** of this Provider Manual for eye care services for members age birth to age 21 years.)
- Emergency dental care, extractions and medically necessary dentures for members 21 years and older. *CALL PRIOR AUTHORIZATION.* (**See Other Programs: EPSDT** of this Provider Manual for dental care services for members age birth to age 21 years.)
- Acute behavioral health services, limited to up to the first 72 hours per episode of emergency/crisis stabilization, not to exceed 12 days per contact

year for those members not enrolled in a Regional Behavioral Health Authority (RBHA). For inpatient admission, *CALL PRIOR AUTHORIZATION.* The PCP may prescribe psychiatric medication(s) to treat ADD/ADHD, mild depression or anxiety. (**See Other Programs: Behavioral Health** of this Provider Manual.)

- Nutritional assessment and nutritional supplements by any route and Total Parenteral Nutrition (TPN). (**See Other Programs: Nutrition** of this Provider Manual.) *CALL PRIOR AUTHORIZATION*
- Private duty nursing. *CALL PRIOR AUTHORIZATION.*
- Hospice for all qualified DD/ALTCS members, regardless of age. *CALL PRIOR AUTHORIZATION.*
- Home Health Nursing. *CALL PRIOR AUTHORIZATION.*
- Covered Services for Dual Eligible Qualified Medicare Beneficiaries (QMB). *CALL PRIOR AUTHORIZATION* for authorization to deliver any of the following QMB services:
  - Chiropractor services
  - Inpatient and outpatient occupational therapy
  - Inpatient psychiatric services
  - Psychological services
  - Respite services
  - Any services covered by or added to the Medicare program which are not covered by AHCCCS.

Non-Covered Services include, but are not limited to:

- Hearing aids, eye examinations for glasses, and prescription lenses for members age 21 years and older
- Routine dental care for members 21 years and older
- Physical therapy prescribed for maintenance reasons only
- Services provided in an institution for the treatment of tuberculosis or for the treatment of mental disorders
- Sex-change operations and operations to reverse voluntary sterilization
- Services or items needed only for cosmetic reasons
- Services that DES/DDD's Medical Director determines to be experimental or provided primarily for research purposes
- Personal care items, like toothbrushes and television sets in hospital rooms
- Routine podiatry (foot and ankle) services, except for members with diabetes or other chronic illnesses

- Orthognathic (jaw) surgery for members age 21 years and older
- Abortions (unless the mother is pregnant through rape or incest or an abortion is needed to save the life of the mother)
- Abortion counseling
- Medical services provided to a person who is an inmate of a public institution or who is in the custody of a state mental health facility.
- Infertility treatment
- Hysterectomies
- Hysteroscopic tubal sterilization (such as Essure Micro-Insert)

Other Programs

Children's Rehabilitative Services (CRS)

CRS, part of the Arizona Department of Health Services (ADHS), provides health care services to individuals with special health care needs. CRS is a statewide, State and Federally funded program which serves individuals under 21 years of age, residing in Arizona at the time of service, who meet the medical and financial criteria established by ADHS. Generally, all DD/ALTCS members meet CRS financial requirements.

CRS accepts for treatment those individuals who have handicapping or potentially handicapping conditions that are likely to improve through medical, surgical, or therapy modalities. The following three criteria must be present:

1. Specialized treatment is necessary;
2. Significant, functional improvement is realistically achievable; and
3. Long-term follow-up may be required for maximum achievable results.

Members under the age of twenty-one (21) who may have a CRS eligible condition must be referred to CRS by completing a CRS application (copy of the application form is in Appendix F) to the appropriate CRS regional office, unless the member chooses to use private insurance. CRS regional offices are located at:

1215 N. Beaver, Flagstaff, AZ 86001	520/773-2053 or 800/232-1018
124 W. Thomas Rd. Phoenix, AZ 85013	602/650-6400 or 800/392-2222
2600 N. Wyatt Drive, Tucson, AZ 85712	520/324-5437 or 800/231-8261
2400 Avenue A, Yuma, AZ 85364	520/344-7095 or call collect

FFS providers are responsible for initiating an application to CRS for members potentially eligible under the CRS program. Referrals for service from CRS should be tracked and monitored by the FFS provider, with follow-up documented in the medical record. Any coordination of care difficulties should be reported to the HCS Prior Authorization Unit.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Federally mandated, EPSDT services provide comprehensive health care, as defined in A.A.C. R9-22-213, through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for eligible members under 21 years of age. EPSDT also provides for all medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening, regardless of whether the treatment or services is covered for other Medicaid eligible members 21 years of age and older. Limitations and exclusions, other than the requirement for medical necessity, do not apply to EPSDT services.

FFS providers must (AHCCCS Medical Policy Manual 430 EPSDT):

1. Provide EPSDT services in accordance with A.A.C. R9-22-213 and 42 CFR 441, Subpart B, and Section 1905 (R) of the Social Security Act.

2. Provide and document EPSDT screening services in accordance with the AHCCCS Periodicity Schedule. (See Appendix G.)

3. Refer members for follow up, diagnosis and treatment, ensuring that treatment is initiated within 60 days of screening services.

4. If appropriate, document in the medical record, the member decision not to participate in the EPSDT Program.

5. Document a health database assessment on each EPSDT participant. The database shall be interpreted by a physician or licensed health professional who is under the supervision of a physician.

6. Provide health counseling/education at initial and follow up visits.

7. Coordinate care with AzEIP and Children's Rehabilitative Services (CRS).

Screening Requirements:

1. EPSDT screenings must include:
   A comprehensive health and developmental history (including physical, nutritional and behavioral health assessments)

   a. **Developmental Screening** – For children from birth through age 5, a developmental history of the infant or child must be obtained and augmented at each well-child scheduled visit and documented in the child's medical record. A child between the ages of 3 through 5 years may be eligible for further assessment if he/she experiences difficulties that interfere with normal development in these areas:

      i. Fine and gross motor skills
      ii. Behavioral/social skills
      iii. Self-help skills
      iv. Speech/language
      v. Problem-solving skills, and
      vi. Cognition/readiness skills

      After the age of 5 years, developmental screening should continue to include information related to cognitive, language, and psychosocial development. The following tests are strongly recommended for children up to 3 years of age and may be used up to the age of 5 years:

      i. Denver Developmental Screening Test (DDST II)
      ii. Revised Developmental Screening Inventory
      iii. Gesell Developmental Examination

For children 3 through 5 years of age, the Early Screening Inventory (Meisels) is available. This instrument is also available in Spanish.

Particular care should be taken to note "red flags" signaling behavioral health problems at each visit. To obtain more information on developmental screening instruments, see Bright Futures Web site: *www.brightfutures.org*

If there is a suspicious outcome on prescreening or screening, and there is no established condition, or the FFS provider does not feel knowledgeable about the assessment instrument/interpretation, then a referral for a developmental evaluation by the Arizona Early Intervention Program providers (AzEIP) is appropriate. Contact the DES/DDD Birth to Five Coordinator, 1789 W. Jefferson, Phoenix, AZ 85006, 480/231-0960, for more information (See **Contacting Us** in the front of this Manual.)

2. A comprehensive unclothed physical examination

3. Appropriate immunizations according to age and health history

4. Laboratory tests (including blood lead screening assessment appropriate to age and risk, anemia testing and diagnostic testing for sickle cell trait if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test)

5. Health Education

6. Appropriate oral health screening, intended to identify gross tooth decay or oral lesions, conducted by a physician, physician's assistant or nurse practitioner

7. Appropriate vision, hearing, and speech testing and diagnosis, as well as treatments for defects in vision and hearing, including provision of eyeglasses and hearing aids. Appropriate therapies, including speech therapy, are also covered under EPSDT, and

8. Tuberculin skin testing as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include those who have contact with persons:

    a. Confirmed or suspected as having TB

    b. In jail or prison during the last five years

    c. Living in a household with an HIV-infected person or the child is infected with HIV, and

    d. Traveling/immigrating from, or having significant contact with person indigenous to, endemic countries.

EPSDT Standards

1. **Immunizations** – EPSDT covers all child and adolescent immunizations as specified in the AHCCCS EPSDT Periodicity Schedule. All appropriate immunizations must be provided to bring, and maintain, each EPSDT member's immunization status up-to-date.

Providers must coordinate with the Arizona Department of Health Services Vaccines for Children program in the delivery of immunization services. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule.

2. **Eye Examinations and Prescriptive Lenses** – EPSDT covers eve examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity.

3. **Blood Lead Screening** – EPSDT covers blood lead screening. All children are considered as risk and must be screened for lead poisoning. All children must receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test result of equal to or greater than 10ug/dl obtained by capillary specimen or fingerstick must be confirmed using a venous blood sample. A verbal risk assessment must be completed at each EPSDT visit for children ages 6 months through 72 months (6 years) to assist in determining risk. Appropriate follow-up must be provided.

4. **Organ and tissue transplantation ser**vices – EPSDT covers medically necessary nonexperimental/noninvestigational organ and tissue transplants approved for reimbursement in accordance with respective transplant policies, as noted in Chapter 300 and Appendix C of the AHCCCS Medical Policy Manual. See Chapter 300 and Appendix C of the AHCCCS Medical Policy Manual for discussion of AHCCCS covered transplantations.

5. **Nutritional Assessment and Nutritional Therapy** –
Nutritional Assessments: Nutrititional assessments are conducted to assist EPSDT members whose health status may improve with nutrition intervention. DES/DDD covers the assessment of nutritional status provided by the member's primary care provider (PCP) as a part of the EPSDT screenings specified in the AHCCCS EPSDT Periodicity Schedule, and on an inter-periodic basis as determined necessary by the member's PCP.

Nutritional Therapy: DES/DDD covers nutritional therapy for EPSDT eligible members on an enteral, parental or oral basis when determined to be medically necessary to provide either complete daily dietary requirements , or to supplement a member's daily nutritional and caloric intake.

a. Enteral nutritional therapy: Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by jejunostomy tube (J-tube), gastrostomy tube (G-tube) or nasogastric (N/G) tube. Prior authorization is required for parenteral nutritional feedings.

b. Parenteral nutritional therapy: Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which doe not allow absorption of sufficient nutrients to maintain weight and strength. Prior authorization is required for parenteral nutritional feedings.

c. Commercial Oral Supplemental Nutritional Feedings: Provides nourishment and increases caloric intake as a supplement to the member's intake of other age appropriate foods, or as the soul source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without a prescription.

Prior authorization is required for commercial oral nutrition supplements unless the member is also currently receiving nutrition through enteral or parenteral feedings. Prior authorization is not required for the first 30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition.

Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or attending physician, using at least the criteria stated in the Chapter 400 of the AHCCCS Medical Policy Manual. The PCP or attending physician must use the "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" form, which can be found on the AHCCCS website at: http://www.ahcccs.state.az.us/Regulations/OSPPolicy/chap400/CP_Policy430.pdf

The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or attending physician has provided nutritional counseling as part of the EPSDT services provided to the member. The documentation must specify alternatives that were tired in an effort to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

d. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements. At least two of the following criteria must be met:

The member is at or below the 10^{th} percentile on the appropriate growth chart for their age and gender for three months or more

The member has reached a plateau in growth and/or nutritional status for more the six months (prepubescent)

The member has already demonstrated a medically significant decline in weight within the past three months (prior to assessment)

The member as able to consume/eat not more than 25% of his/her nutritional requirements from age-appropriate food sources

Absorption problems as evidenced by emesis, diarrhea, dehydration, and/or weight loss and intolerance to milk or formula products has been ruled out, or

The member requires nutritional supplements on a temporary basis due to an emergent condition; i.e. post-hospitalization. Prior authorization is not required for the first 30 days.

6. **Oral Health Services** – As part of the physical examination, the physician, physician's assistant or nurse practitioner should perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Depending on the results of the oral health screening, referral to a dentist should be made according to the following timeframes:

Category	Recommendation for Next Dental Visit	Criteria
Urgent	Within 24 hours	Pain, infection, swelling and/or soft tissue ulceration of approximately two weeks duration or longer.
Early	Within three weeks	Decay without pain, spontaneous bleeding of the gums and/or suspicious white or red tissue areas
Routine	Next regular checkup	None of the above problems identified

An oral health screening should be part of an EPSDT screening conducted by the PCP, however it does not substitute for examination through direct referral to a dentist. PCPs are expected to refer EPSDT member for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral should be documented on the EPSDT form. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is an AHCCCS registered provider.

Note: Although the AHCCCS EPSDT Periodicity Schedule identifies when routine referrals begin, PCPs may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional.

EPSDT covers the following dental services:

a. Emergency dental services including:

Treatment for pain, infection, swelling and/or injury

Extraction of symptomatic, infected and non-restorable primary and permanent teeth, as well as retained primary teeth, and

General anesthesia or conscious sedation when local anesthesia is contraindicated or when management of the patient requires it.

b. Preventative dental services provided as specified in the AHCCCS EPSDT Periodicity Schedule, including:

Complete intraoral examinations

Radiology procedures which are screening in nature for diagnosis of dental abnormalities, including panography or full-mouth x-rays, su;;lemental bitewing x-rays, and occlusal or periapical films as needed

Oral prophylaxis performed by a dentist or dental hygientist which includes instruction in self-care oral hygiene procedures

Application of topical fluorides. (Use of prophylaxis paste containing fluoride and fluoride mouth rinses are not considered separate fluoride treatments), and

Dental sealants on all non-carious permanent first and second molars and second primary molars.

c. All therapeutic dental services will be covered when they are considered medically necessary but may be subject to prior authorization. These services include but are not limited to:

Periodontal procedures, scaling/root planning, curettage, gingivectomy, osseous surgery

Space maintainer when posterior primary teeth are lost permanently

Crowns

Stainless steel crowns may be used for both primary and permanent posterior teeth; composite, plastic or acrylic crowns must be used for anterior primary teeth, or

Cast non-precious or semi-precious crowns for members 18 through 20 years of age on all functional permanent endodontically treated teeth, except third molars

Pulp therapy for permanent and primary teeth, except third molars unless it is functioning in place of a missing molar

Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 through 20 years of age and has had endodontic treatment, and

Dentures, orthodontics and orthognathic surgery when medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan designed by the PCP in consultation with the dentist.

7. **Cochlear Implantation** – Cochlear implantation provides an awareness and identification of sounds and facilitates communication for persons who have profound, sensorineural hearing loss (nerve deafness). DES/DDD covers medically necessary services for cochlear implantation, as described in Chapter 300, Policy 310 of the AHCCCS Medical Policy Manual, for EPSDT members eighteen months of age or older who meet the following criteria:

Have a diagnosis of bilateral profound sensorineural deafness, with little or no benfit from a hearing (or vibrotactile) aid,as established by audiologic and medical evaluation

Deafness may be prelingual/perilingual or postlingual

Have an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation

Demonstrate no contraindications to surgery, and

Demonstrate age appropriate cognitive ability to use auditory clues.

Cochlear implantation requires prior authorization.

8. **Conscious sedation** – DES/DDD covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that allows the member to tolerate an unpleasant procedure while remaining able to continuously maintain adequate cardiovascular and respiratory function as well as the ability to respond purposely to verbal command and/or tactile stimulation.

Coverage is limited to the following procedures:

a. Bone marrow biopsy with needle or trocar

b. Bone marrow aspiration

c. Intravenous chemotherapy administration, push technique

d. Chemotherapy administration into central nervous system by spinal puncture

e. Diagnostic lumbar spinal puncture, and

f. Therapeutic spinal puncture for drainage of cerebrospinal fluid.

Additional applications of conscious sedation for members receiving EPSDT services will be considered on a case by case basis and require medical review and prior authorization by the DES/DDD Medical Director.

9. **Behavioral health services** as described in Chapter 300, Policy 310 of the AHCCCS Medical Policy Manual

10. **Religious Non-Medical Health Care Institution Services** as described in Chapter 300, Policy 310 of the AHCCCS Medical Policy Manual

11. **Case Management Services**

12. **Chiropractic Services**, and

13. **Personal Care Services**

EPSDT Periodicity Schedule

AHCCCS has established an EPSDT Periodicity Schedule which describes at what age children should be seen for preventive care and which services are required at each age. A copy of the Periodicity Schedule is in Appendix G. The FFS Provider is required to adhere to the Periodicity Schedule and to document screening and treatment results on the EPSDT Tracking Forms. The tracking Forms may be found on the AHCCCS website at www.ahcccs.state.az.us

As examples, EPSDT visits should be coded as follows on the CMS 1500:

Patient Status	ICD-9 Diagnosis Code	CPT-4 Procedure Code
New Patient EPSDT	V20.2	99381
Established Pt.	V20.2	99392
with Immunization	V20.2	90707

Follow-up visits for an acute condition (i.e., otitis) can also be occasions for an EPSDT screen. Code the CMS 1500 with the appropriate ICD-9 diagnosis codes (i.e., 382.9 for otitis and V20.2 for EPSDT visit) and indicate the appropriate procedure code(s) applicable to each diagnosis (i.e., 99392 for diagnoses 1 and 2).

Vaccines for Children (VFC) Program

FFS Providers who treat DD/ALTCS members under age 18 years must participate in

the VFC Program. This program is coordinated through the Arizona Department of Health Services (ADHS). To participate, providers must complete a Provider Enrollment form and a Provider Profile. These documents may be obtained from ADHS by calling the ADHS VFC representative at 602/364-3642. Providers receive information on ordering vaccines from AHDS after the enrollment process is completed. Vaccines for VFC eligible children may be ordered once every two months. Questions regarding VFC provider enrollment and vaccine ordering should be directed to the ADHS VFC program at **(602)** 364-3642.

Therapy

If therapy is post surgery or acute condition, i.e. fracture, the therapy must be designed to restore a similar level of functions to what was present prior to surgery/acute condition, unless the intervention was designed to increase function, as with release of contractures. In this case, post intervention therapy is covered as rehabilitative.

DES/DDD has adopted a teaching model for the delivery of therapies (physical, speech, occupational). The FFS Provider is encouraged and requested to adhere to this model which includes education of and participation from the member and caregiver(s). DES/DDD believes that therapy services are an essential component of programs for adults and children who need to maintain or improve their functional capabilities and physical well-being. The direction and oversight of a therapist is a valuable resource which must be effectively utilized to achieve maximum benefit and cost-effectiveness. Ideally there is a shared effort between the therapist and the family, caregivers, service providers and teachers. Activities recommended by a therapist should be integrated into the member's daily routine and, in most cases, be performed frequently and routinely by the member and/or caregiver(s).

In the teaching model, the primary role of the therapist is:

- to evaluate the member,
- to recommend and design sound activities and methodologies,
- to teach and assist caregivers to incorporate these into the member's daily routine,
- to provide direct therapy when necessary and appropriate, and
- to evaluate and monitor implementation and progress.

Behavioral Health

Emergency/crisis behavioral health services are covered for DD/ALTCS members. For those members not enrolled in a RBHA (Regional Behavioral Health Authority) at the time of the emergency, up to 72 hours of emergency psychiatric hospitalization may be authorized by HCS's Prior Authorization Unit. This service is limited to 12 days per contract year for those members not enrolled in a RBHA.

Each Regional Behavioral Health Authority (RBHA) is required to provide a full array of medically necessary behavioral health services. Members may also receive behavioral health services from their PCP, depending on the PCP's level of comfort, when presenting with certain mental health disorders (ADD/ADHD, mild depression or

anxiety). The PCP may consult with a RBHA psychiatrist about diagnostic and treatment questions or may arrange for a DD/ALTCS member to have a one time face-to-face consultation with a RBHA psychiatrist when clinically indicated. The PCP may also elect to refer the member to a RBHA as soon as a behavioral health need is identified. There are multiple points of entry into the RBHA behavioral health system. The member may apply, the DDD Support Coordinator, PCP, guardian, parent, or anyone familiar with the person may assist with a referral to the local RBHA. (See Appendix H for a map and names/addresses of the Arizona RBHAs. Also included is a RBHA referral form, which should be used for referrals and consultations.)

FFS providers are responsible for initiating an application to the RBHA for members potentially eligible under the RBHA system, when the behavioral health need is identified by the FFS provider. Referrals for service from the RBHA should be tracked and monitored by the FFS provider, with follow-up documented in the medical record. Any coordination of care difficulties should be reported to the HCS Administrator.

Nutrition

Enteral nutrition by any route (i.e., mouth, tube), is covered for any age member, based on medical necessity. Enteral nutrition includes nutritional products which serve as either the primary source of nutrition and/or supplemental nutrition. Supplies to administer the feeding are also covered. The FFS Provider is also expected to assist in the development and implementation of protocols and procedures to encourage weaning from enteral nutrition and to assist the caregiver in the weaning process.

TPN is covered for any age member, based on medical necessity. Supplies and administration of parenteral nutrition are covered. If TPN is required for more than six (6) months, continued need beyond the initial six months requires PA, with annual review thereafter for continued authorization.

Women, Infants and Children (WIC)

DES/DDD recognizes the value of the Women, Infants & Children (WIC) program in providing nutritional guidance as well as beneficial food commodities. All ALTCS members are eligible for services typically provided by WIC through the DD/ALTCS program and its FFS providers. Members cannot be denied by first requiring members to utilize WIC.

Dental Services

Children are eligible under EPSDT for a wide range of dental services. Prophlyaxis and fluoride treatment is covered once every 6 months. Sealants are covered for non-carious permanent first molars. Children may receive dental treatment for traumatic injuries, caries, developmental abnormalities, evidence of infection, bleeding, or inflammation of gums, and/or decay of erupting teeth.

Adults dental coverage is limited to emergency dental services and medically necessary

dentures. Dental implants are not covered. Dental emergencies must meet the AHCCCS definition of an emergency medical condition [R9-22-101(44)]. Medically necessary dentures are partial or full dentures determined to be the best treatment to alleviate a medical condition. Call Prior Authorization.

Home Modifications

DES/DDD covers the cost of home modifications or items which will allow members to function as independently as possible. Typical modifications are widening of doorways for better access, replacing bathroom tubs with roll-in-showers for wheelchair accessibility and building ramps to better negotiate entrance doorways.

This service must be determined medically necessary and prescribed by the primary care provider. Please refer members requesting this service to their DDD Support Coordinator to initiate the referral process.

Augmentative Communication

DES/DDD covers augmentative/alternative communication devices for members who have a functional gap between receptive and expressive language skills. Based on individual need, devices may range from simple picture books to hi-tech electronic communication aids.

This service must be determined medically necessary and prescribed by the primary care

provider. Please refer members requesting this service to their DDD Support Coordinator to initiate the referral process.

Transition and Coordination of Care

In the event that the agreement between the Division and a fee-for-service provider is terminated, with or without cause, or the Division contracts with a health plan in the FFS Provider's area, the provider shall assist the Division in the transition of members to other health care providers. In addition, the provider shall assist with the coordination of care for members entering or leaving DD/ALTCS services. Such assistance and coordination shall include, but is not limited to, the forwarding of medical and other records, the facilitating and scheduling of record transmittal and medically necessary appointments. The cost of reproducing and forwarding medical charts and other materials shall be borne by the provider.

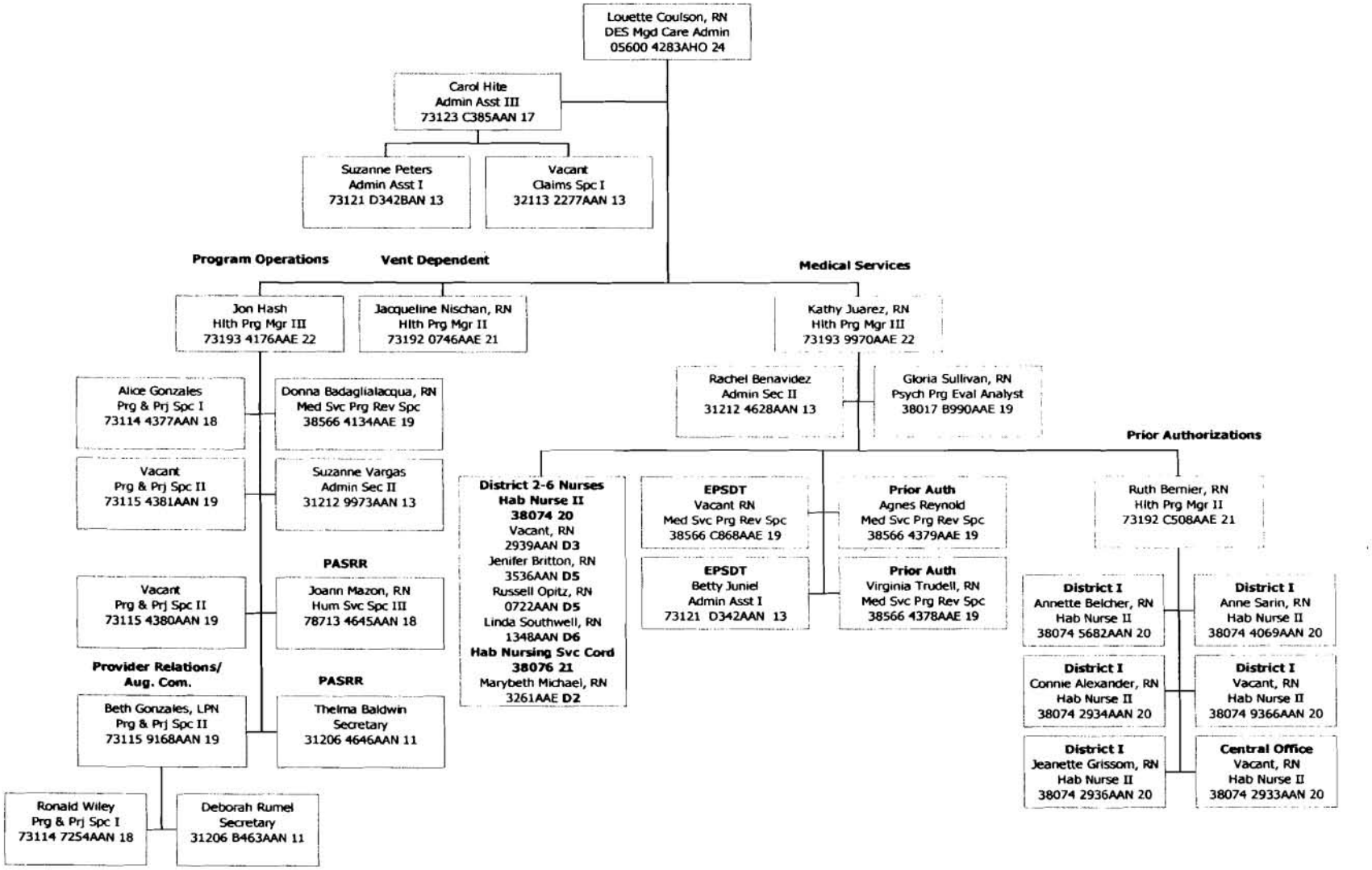
APPENDIX A:

HCS TABLE OF ORGANIZATION

AND

PROVIDER RELATIONS GEOGRAPHIC ASSIGNMENT MAP

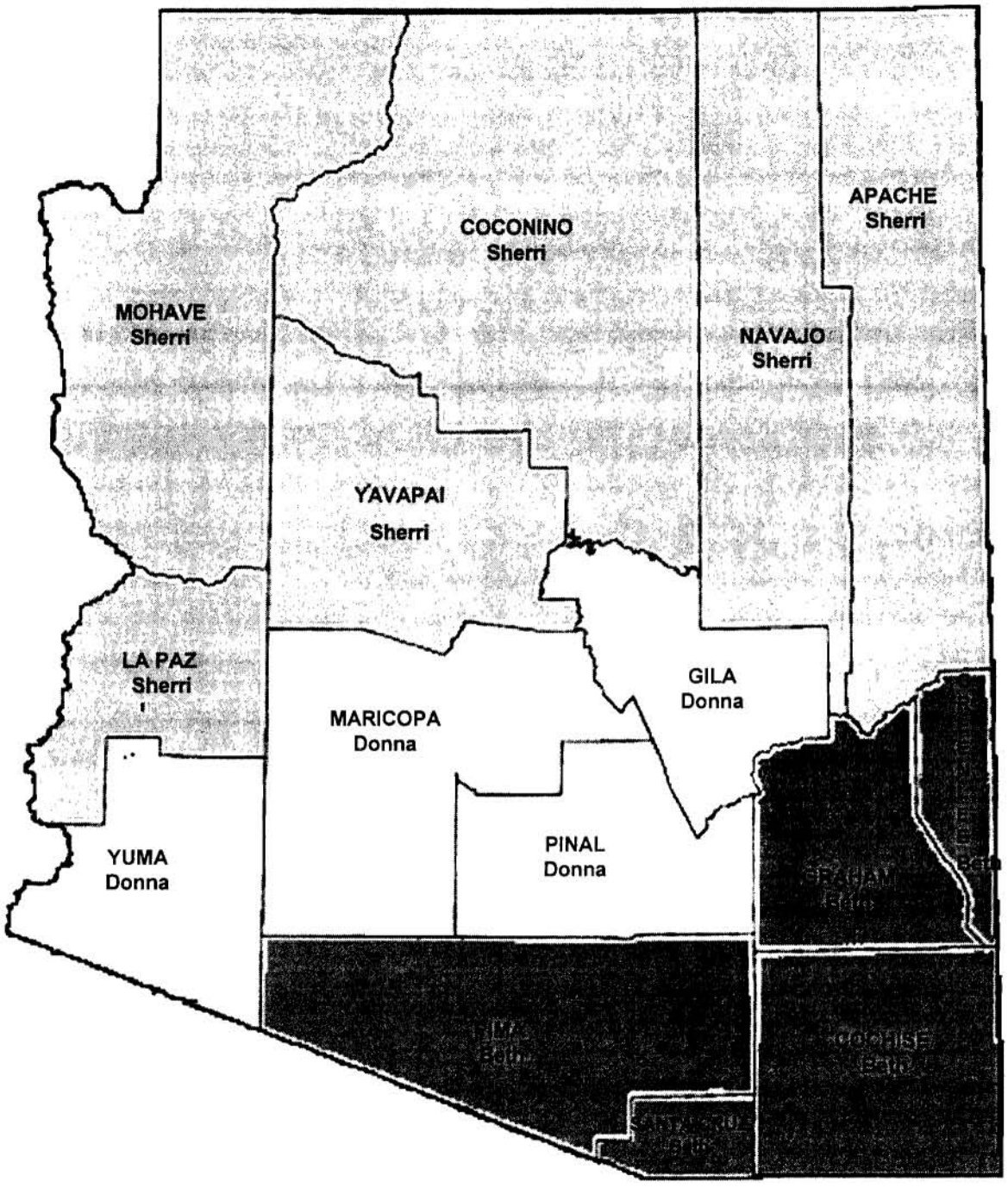
Central Office - Health Care Services



Division of Developmental Disabilities

Health Care Services

Arizona Provider Relations



	Name	Telephone	Fax
	Sherri Ashbaugh	928-773-4957 ext. 2227	928-773-8495
	Donna Badaglialacqua	602-238-9028 ext. 6026	602-238-9294
	Beth Gonzales	602-238-9028 ext. 6010	602-238-9294

APPENDIX B:

DISTRICT NURSE CONTACTS

DDD NURSES LIST

NAME	ADDRESS	SITE CODE	PHONE AND VOICE MAIL	PAGER
AGNES REYNOLDS Areynolds@azdes.gov\	2200 N. CENTRAL, SUITE 506 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6038	NONE
ALICIA MADDEN Amadden@azdes.gov	P.O. BOX 13178 TUCSON, AZ 85711	275-F	520-519-1726 Ext. 1088	NONE
ALISON WILSON AlisonWilson@azdes.gov	P.O. BOX 1467 COOLIDGE, AZ 85228	575-F	520-723-4151 Ext. 1216	520-374-8208 Coolidge
ANN LYNCH Alynch@azdes.gov	P.O. BOX 13178 TUCSON, AZ 85711	275-F	520-519-1726 Ext. 1090	NONE
ANNE SARIN Asarin@azdes.gov	2200 N. CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6002	NONE
ANNETTE LAMMON-BELCHER Abelcher@azdes.gov	2602 S. 24TH ST., SUITE #108 PHOENIX, AZ 85034	116-F	602-231-9218 Ext. 1011 VM 602-238-9028 Ext. 6105	NONE
ANNICK RAPPOLE Arappole@azdes.gov	P.O. BOX 13178 TUCSON, AZ 85711	275-F	520-519-1726 Ext. 1087	NONE
BERNICE BAUM BerniceBaum@azdes.gov	ATPT BOX 13178 TUCSON, AZ 85732	275-F	520-519-1726 Ext. 1086	NONE
CARA FRIDAY Cfriday@azdes.gov	2200 N. CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6022	NONE
CHERYL MENDOZA Cmendoza@azdes.gov	910 N. BROAD STREET GLOBE, AZ 85501	510-F	VM 602-238-9028 Ext. 6100	NONE
CONNIE ALEXANDER ConstanceAlexander@azdes.gov	2200 N. CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6112	NONE
CYNTHIA GUZMAN CynthiaGuzman@azdes.gov	2200 N. CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6023	NONE
DEE BECKETT Dbeckett@azdes.gov	ATPT BOX 13178 TUCSON, AZ 85732	275-F	520-745-5588	NONE
DONNA ALVARADO dalvarado@azdes.gov	ATPT BOX 13178 TUCSON, AZ 85732	275-F	520-745-5588	NONE
DONNA POOL Dpool@azdes.gov	519 E BEALE ST. SUITE 155 KINGMAN, AZ 86401	402-F	928-753-4868 VM 800-624-4964 Ext. 6104	Cell 928-716-0571
GLORIA SULLIVAN Gsullivan@azdes.gov	2200 N. CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6033	NONE
JACKIE NISCHAN Jnischan@azdes.gov	2200 N. CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6009	NONE
JANIE MEHRBRODT Jmehrbrodt@azdes.gov	2200 N. CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6016	NONE
JEANETTE GRISSOM Jgrissom@azdes.gov	2200 N. CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6110	NONE
JENIFER BRITTON Jbritton@azdes.gov	232 LONDON BRIDGE ROAD LAKE HAVASU CITY, AZ 86403	421-F	VM 602-238-9028 Ext. 6107 VM 800-624-4964 Ext. 6107	NONE
JUDY STOYCHEFF Jstoycheff@azdes.gov	1000 AINSWORTH DRIVE PRESCOTT, AZ 86301	342-F	928-778-5290 Msg Phone 928-778-7921	Cell 928-925-4797
KATHY JUAREZ Kjuarez@azdes.gov	2200 N. CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6035	NONE
LINDA SOUTHWELL Lsouthwell@azdes.gov	1938 THATCHER BOULEVARD SAFFORD, AZ 85546	631-F	928-428-0474 Ext.1140	NONE
LORI WHETTEN Lwhetten@azdes.gov	2500 E. COOLEY #410 SHOW LOW, AZ 85901	336-F	VM 602-238-9028 Ext. 6108	NONE
LOUETTE COULSON Lcoulson@azdes.gov	2200 N. CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6012	NONE
MARYBETH MICHAEL Mmichael@azdes.gov	4710 E. 29TH STREET TUCSON, AZ 85711	275-F	520-745-5588 Ext. 1085	NONE
MARILYN COOKE Mcooke@azdes.gov	1900 W. CAMELBACK ROAD PHOENIX, AZ 85015	868-F-2	602-246-0309	NONE
NORMA SHOWALTER Nshowalter@azdes.gov	P.O. BOX 13178 TUCSON, AZ 85711	275-F	520-519-1726 Ext. 1084	NONE
RUTH BERNIER Rbernier@azdes.gov	2200 N. CENTRAL, SUITE 506 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6034	NONE
RUSSELL OPITZ Ropitz@azdes.gov	ATPC P.O. BOX 1467 COOLIDGE, AZ 85258	575-F	520-723-4151 Ext. 1334 VM 602-238-9028 Ext. 6102	NONE
SANDY PAHL Spahl@azdes.gov	2200 N. CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6017	NONE
SALLIE MOSES Smoses@azdes.gov	1990 W. CAMELBACK ROAD PHOENIX, AZ 85015	868-F2	602-246-0309	NONE
TRUDY TRUDELL Ttrudell@azdes.gov	2200 N. CENTRAL, SUITE 506 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6036	NONE

APPENDIX C:

PRIOR AUTHORIZATION (PA) FORMS

Division of Developmental Disabilities (DDD) – Health Care Services (HCS)
Authorization Request Form
FAX To: 602-253-9083

Name of Company: ______________________ Provider AHCCCSID: ______________

Contact Person: ______________ Phone #: ____________ FAX #: ____________

Client Name: ______________ **Date of Birth:** ____________ **AHCCCS Id:** ____________

Diagnosis Codes/Description: ____________ ____________ ____________ ____________

Other Insurance: ______________ **Policy #:** ______________ **Phone #:** ____________

Authorization #: ______________ **Date of Service:** __________ **Thru:** __________

List of Monthly Durable Medical Equipment Rentals and Supplies

HICPIC	Code Modifier * NU/RR	Description	Script Date	Check if new Item	Unit(s) Per Month	Check if One Time Purchase	Price	
				☐		☐	$	
				☐		☐	$	
				☐		☐	$	
				☐		☐	$	
				☐		☐	$	
				☐		☐	$	
				☐		☐	$	
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				☐		☐	$	
				☐		☐	$	
				☐		☐	$	
				☐		☐	$	
				☐		☐	$	
				☐		☐	$	

* NU = New Purchase RR = Rental

For DDD-HCS Use Only:
Auth #: Date Faxed:
DOS From: DOS Thru:
Signature: ______________________

Send Claims to: DES/DDD
Attn: DDD Acute Care Claims Department
P.O. Box 6123 - Site Code 791A
Phoenix, Arizona 85005-6123

INPATIENT
DES/DDD AUTHORIZATION REQUEST
PA DEPARTMENT PHONE #(602) 238-9028 / PA DEPARTMENT FAX#: (602) 253-9083

IN ORDER TO PROCESS AN AUTHORIZATION, THE FOLLOWING INFORMATION MUST BE PROVIDED:

REQUEST DATE____/_____/_____ PERSON REQUESTING PA_____
PHONE_____
FAX_____

PATIENT NAME_____ DOB_____/_____/_____
PATIENT AHCCCS ID#:_____ CRS COVERED? NO [ ] YES [ ]
OTHER INSURANCE INFO_____

FACILITY NAME:_____ FACILITY AHCCCS ID #:_____
FACILITY ADDRESS_____

DIAGNOSIS DESCRIPTION

DIAGNOSIS CODE (I.E. ICD 9): _____ _____
_____ _____
_____ _____

ADMIT DATE ____/____/_____ ADMIT TIME_____ DISCHARGE DATE ____/_____/_____
DISCHARGE TIME ____/_____/_____

ADMIT DOCTOR_____ DOCTOR AHCCCS ID#_____

ROOM #_____ TIER LEVEL (I.E. ICU, PEDS, ETC.)_____

UNIT PHONE#_____ UR DEPT/RN PHONE#_____

PLEASE FAX THE ABOVE INFORMATION TO DES/DDD FAX #: (602) 253-9083

AUTHORIZATION DEPARTMENT ONLY

AUTHORIZATION #:_____GIVEN TO_____ [ ] CALLED [ ] FAXED

PA NURSE_____ DATE____/____/____ TIME_____

Updated: 02/04/04

INPATIENT
DES/DDD AUTHORIZATION REQUEST
PA DEPARTMENT PHONE #(602) 238-9028 / PA DEPARTMENT FAX#: (602) 253-9083

IN ORDER TO PROCESS AN AUTHORIZATION, THE FOLLOWING INFORMATION MUST BE PROVIDED:

REQUEST DATE____/_____/_____ PERSON REQUESTING PA_____
PHONE_____
FAX_____

PATIENT NAME_____ DOB_____/_____/_____
PATIENT AHCCCS ID#:_____ CRS COVERED? NO [ ] YES [ ]
OTHER INSURANCE INFO_____

FACILITY NAME:_____ FACILITY AHCCCS ID #:_____
FACILITY ADDRESS_____

DIAGNOSIS CODE (I.E. ICD 9): _____ DIAGNOSIS DESCRIPTION
_____
_____
_____

ADMIT DATE ____/____/_____ ADMIT TIME_____ DISCHARGE DATE ____/_____/_____
DISCHARGE TIME ____/_____/_____

ADMIT DOCTOR_____ DOCTOR AHCCCS ID#_____

ROOM #_____ TIER LEVEL (I.E. ICU, PEDS, ETC.)_____

UNIT PHONE#_____ UR DEPT/RN PHONE#_____

PLEASE FAX THE ABOVE INFORMATION TO DES/DDD FAX #: (602) 253-9083

AUTHORIZATION DEPARTMENT ONLY

AUTHORIZATION #:_____GIVEN TO_____ [ ] CALLED [ ] FAXED

PA NURSE_____ DATE____/____/_____ TIME_____

MAIL CLAIMS TO:

DES/DDD
P.O. Box 6123
Site Code 791A
Attention: DDD Claims
Phoenix, AZ 85005-6123

Updated: 10/03/03

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
DIVISION OF DEVELOPMENTAL DISABILITIES

EQUIPMENT ORDER WORKSHEET

Client:_____ AHCCCS ID: _____DOB:_____
Home Address:_____
Phone: _____
Deliver To: _____
_____
Diagnosis:_____
Physician:_____ Script Attached: Yes [ ] No [ ]

	Equipment	Quote
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____

Total: _____

[ ] Medicare ID: _____
[ ] Insurance: _____ ID: _____
Address: _____ Phone:_____
_____ Subscriber: _____

DDD Support Coordinator/Case Worker_____
Phone #_____ Fax #_____
Date Notified of Order_____
Order Called To_____ Provider _____
Date/Time_____ Phone # _____ Fax # _____
Provider ID _____
Prior Auth #_____ Good Thru _____

Prior Auth Nurse:_____ Phone: _____

Send Claims To: DES/DDD
P.O. Box 6123
Site Code 791A
Phoenix, AZ 85005

DDD/LTC EQUIPMENT AND SUPPLIES REQUISITION

FAX COMPLETED INFORMATION TO DES/DDD PRIOR AUTHORIZATION AT FAX# 602-253-9083 OR MAIL TO: DDD HEALTH CARE SERVICES 2200 N. CENTRAL AVE SUITE 506 PHX, AZ 85004

In order to process an authorization, please complete top portion of form:

Date: _____ **Support Coordinator/Case Worker:** _____
Phone: _____ **Fax:** _____
Member's Name: _____ **Date of Birth** _____
Home Address: _____ **Home Phone:** _____
_____ **AHCCCS ID#** _____
DDD Diagnosis _____ **Height** _____ **Weight** _____
Other Insurance: _____ **Policy Holder** _____
Policy Number _____ **Insurance Phone Number** _____

		APPROVED	DENIED
ITEMS REQUESTED:	(1) _____	[ ]	[ ]
	(2) _____	[ ]	[ ]
	(3) _____	[ ]	[ ]
	(4) _____	[ ]	[ ]
	(5) _____	[ ]	[ ]

PLEASE SEND:

[X] Picture of item requested
[X] Physician order/prescription _____[DATE]
[X] Medical Justification (Can be obtained from Physician and/or physical therapist involved _____[Date]
[ ] PT/OT Evaluation(when required)
[ ] ISP Decision Date of Decision _____SC/CW Signature _____

*******PRIOR AUTHORIZATION DEPARTMENT USE ONLY*******

Date Received: ___/___/_____ [ ] Medicare
(MCO) [ ] Primary Insurance

	Company	Sent/Received	Quote
(1)	_____	_____	_____
(2)	_____	_____	_____
(3)	_____	_____	_____

PROVIDER: _____
PRIOR AUTHORIZATION NUMBER_____ [ ] FAXED TO: _____
[ ] CALLED TO: _____

PA NURSE: _____
DATE ORDERED/TIME: _____

REVISED 2/14/03 **KS:bj**

OFFICE/CLINIC/ER VISITS
DES/DDD AUTHORIZATION REQUEST
PA DEPARTMENT PHONE #: (602) 238-9028 FAX #: (602) 253-9083

IN ORDER TO PROCESS AN AUTHORIZATION, THE FOLLOWING INFORMATION MUST BE PROVIDED:

REQUEST DATE____/____/____ PERSON REQUESTING PA_____

PHONE_____

FAX_____

PATIENT NAME_____ DOB____/____/____

PATIENT AHCCCS ID#:_____ CRS [ ] TRAUMA [ ] INDUSTRIAL [ ] PSYC [ ]

PROVIDER NAME:_____ PROVIDER AHCCCS ID #:_____

PROVIDER ADDRESS:_____

	DIAGNOSIS DESCRIPTION
DIAGNOSIS CODE (I.E.ICD 9): _____	_____
_____	_____
_____	_____
_____	_____

BILLING CODE	MODIFIER CODE	DESCRIPTION	DOS
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____

ADDITIONAL INFORMATION NEEDED FOR OFFICE/CLINIC VISIT

DOS____/____/____ DOCTOR_____ DOCTOR AHCCCS ID#_____

REASON FOR VISIT_____

PLEASE FAX THE ABOVE INFORMATION TO DES/DDD FAX #: (602) 253-9083

AUTHORIZATION DEPARTMENT ONLY

AUTHORIZATION #:_____ GIVEN TO_____ [ ] CALLED [ ] FAXED

PA NURSE_____ DATE____/____/____ TIME_____

AUTHFRM 11/10/99

OUTPATIENT/PROCEDURE
DES/DDD AUTHORIZATION REQUEST
PA DEPARTMENT PHONE #(602) 238-9028 / PA DEPARTMENT FAX#: (602) 253-9083

IN ORDER TO PROCESS AN AUTHORIZATION, THE FOLLOWING INFORMATION MUST BE PROVIDED:

REQUEST DATE____/_____/_____ PERSON REQUESTING PA_____

PHONE_____ FAX_____

PATIENT NAME_____ DOB_____/_____/_____

PATIENT AHCCCS ID#:_____ CRS COVERED? NO [ ] YES [ ]

PROVIDER NAME:_____ PROVIDER AHCCCS ID #:_____

PHYSICIAN NAME:_____ PHYSICIAN AHCCCS ID #:_____

	DIAGNOSIS DESCRIPTION
DIAGNOSIS CODE (I.E. ICD 9): _____	_____
_____	_____
_____	_____

BILLING CODE	MODIFIER CODE	DESCRIPTION	DOS
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____

AUTHORIZATION DEPARTMENT ONLY

AUTHORIZATION #:_____ GIVEN TO_____ [ ] CALLED [ ] FAXED

PA NURSE_____ DATE____/____/____ TIME_____

MAIL CLAIMS TO:

DES/DDD
P.O. Box 6123
Site Code 791A
Attention: DDD Claims
Phoenix, AZ 85005-6123

Updated: 01/09/04

DES/DDD TRANSPORT AUTHORIZATION REQUEST
PRIOR AUTHORIZATION PHONE 602-238-9028 or toll-free 800-624-4964 FAX 602-253-9083

IN ORDER TO PROCESS AN AUTHORIZATION, THE FOLLOWING INFORMATION MUST BE PROVIDED:

REQUEST DATE ___/___/_____
INDIV. CALLING PROVIDER W/REQUEST: _____
PHONE: _____

MEMBER NAME_____
MEMBER AHCCCS ID#_____
MEMBER DATE OF BIRTH_____

PROVIDER_____
NAME_____PHONE_____FAX_____
CONTACT_____
PROVIDER AHCCCS ID#_____
DOS ___/___/____
BILLING CODES: BASE _____/_____
CODE UNIT
MILEAGE _____/_____
CODE UNIT

DOES FAMILY HAVE A MEANS FOR TRANSPORTATION ? YES_____ NO_____

MEDICAL REASON FOR TRANSPORT_____

FROM _____ TO _____

TYPE OF TRANSPORT _____ P/U TIME _____ APPT TIME _____

[ ] ONE WAY [ ] ROUND TRIP

[ ] RUN SHEET IS REQUIRED FOR AIR OR GROUND AMBULANCE TRANSPORT

PLEASE FAX THE ABOVE INFORMATION TO DES/DDD PRIOR AUTHORIZATION FAX # 602-253-9083
**********AUTHORIZATION DEPARTMENT ONLY*************

AUTHORIZATION # _____ GIVEN TO_____
[ ]CALLED [ ] FAXED

PA NURSE_____ DATE___/___/___TIME_____

Revised 7/7/2004

DES/DDD DIAGNOSTIC AUTHORIZATION REQUEST
PA DEPARTMENT PHONE #(602) 238-9028 / PA DEPARTMENT FAX#: (602) 253-9083

IN ORDER TO PROCESS AN AUTHORIZATION, THE FOLLOWING INFORMATION MUST BE PROVIDED:

REQUEST DATE____/____/____ PERSON REQUESTING PA_____

PHONE #:_____

PATIENT NAME_____ DOB____/____/____

PATIENT AHCCCS ID#:_____

PROVIDER NAME:_____ PROVIDER AHCCCS ID #:_____

PROVIDER ADDRESS:_____ PROVIDER PHONE #:_____
FAX #:_____

PHYSICIAN REQUESTING PA_____ PHYSICIAN AHCCCS ID #:_____

DIAGNOSIS CODE (I.E. ICD 9):	DIAGNOSIS DESCRIPTION
_____	_____
_____	_____
_____	_____

BILLING CODE	MODIFIER CODE	DESCRIPTION	DOS
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____

COMMENTS:_____

AUTHORIZATION DEPARTMENT ONLY

AUTHORIZATION #:_____ GIVEN TO_____ [ ] CALLED [ ] FAXED

PA NURSE_____ DATE____/____/____ TIME_____

Updated: 01/09/04

APPENDIX D:

PREHOSPITAL MEDICAL CARE DIRECTIVE (ADVANCE DIRECTIVE)

SAMPLE FORM

PREHOSPITAL MEDICAL CARE DIRECTIVE

SIDE ONE

(By A.R.S. 36-3251.B this form must be printed on orange paper.)

I refuse the following: (check **only** those treatments you **refuse**)

- ☐ 1. Chest compression
- ☐ 2. Defibrillation
- ☐ 3. Assisted ventilation
- ☐ 4. Intubation
- ☐ 5. Advanced life support medications

Patient: _____ Date: _____
patient's signature or mark

Attach recent photograph here
or provide all of the following information below:

RECENT PHOTOGRAPH

Date of Birth _____

Sex _____

Eye Color _____ Hair Color _____

Race _____

Hospice Program (if any) _____

Name and telephone number of patient's physician

*both sides **must** be completed!*

PREHOSPITAL MEDICAL CARE DIRECTIVE

SIDE TWO

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care checked above or on Side One of this form.

_____ *Date* _____

Licensed health care provider

I was present when this was signed (or marked). The patient then appeared to be of sound mind and free from duress.

_____ *Date* _____

Witness

*both sides **must** be completed!*

APPENDIX E:

ADAPTIVE AIDS LIST

Durable Medical Equipment/Adaptive Aids List

Durable medical equipment and adaptive aids must be medically necessary and prescribed by the PCP, or other provider upon referral by the PCP. Documentation from physician and therapist must establish the need for the equipment, the risk to the member without the equipment, and include a comprehensive explanation of how the member will benefit from the equipment. Covered durable medical equipment and adaptive aids should not duplicate existing equipment provided to the member.

The Division has developed criteria for approval of high frequency chest wall oscillation vests and enclosed/restraint beds, which may be requested by contacting your Provider Relations Representative.

Covered adaptive aids are limited to:

1. Traction equipment
2. Feeding aids, including trays for wheelchairs and adapted feeding utensils
3. Helmets
4. Standers, prone and upright
5. Toileting aids, including bedpans and urinals for bed bound members, commodes
6. Bathing aids, including shower chairs, bath chairs, portable baths, hand-held shower heads
7. Wedges for positioning
8. Transfer aids including portable lifts, such as Hoyer, Voyager, Trixie. When determined medically necessary as part of a DES/DDD approved environmental modification, Subcontractor is responsible to provide the recommended lift and DES/DDD will provide the non-portable tracking system and non-portable tracking system installation.
9. Grab bars, i.e. shower and toilet, including installation
10. Car seats required for transport due to the physical condition of the member which considers head and trunk control, airway obstruction potential, presence of potential for scoliosis, and/or presence of seizure activity
11. Other items determined to be medically necessary by joint consultation of the Medical Directors of Subcontractor and DES/DDD.

APPENDIX F:

CRS REFERRAL FORM

ARIZONA DEPARTMENT OF HEALTH SERVICES
CHILDREN'S REHABILITATIVE SERVICES (CRS)

Please send this form to the clinic nearest you:

124 W. Thomas Rd., Phoenix, AZ 85013 (800) 392-2222 Tel-(602) 406-5731 or Fax-(602) 406-7166
2600 N. Wyatt Dr., Tucson, AZ 85712 (800) 231-8261 Tel-(520) 324-5437 or Fax-(520) 324-3084
1200 N. Beaver, Flagstaff, AZ 86001 (800) 232-1018 Tel-(928) 773-2054 or Fax-(928) 773-2286
2400 Avenue A, Yuma, AZ 85364 (800) 837-7309 Tel-(928) 336-7095 or Fax-(928) 336-7497

CRS APPLICATION FORM

TODAY'S DATE:

CHILD'S NAME (Last, First, Middle)	RACE	SEX ☐ M ☐ F	DATE OF BIRTH (mo/day/yr) / /

PARENT OR GUARDIAN (Last Name, First Name) — RELATIONSHIP TO CHILD ☐ Natural Parent (s) ☐ Adoptive ☐ Foster ☐ Other

CHILD'S ADDRESS STREET	CITY	STATE	ZIP CODE	COUNTY	US Citizen Yes or No

HOME TELEPHONE ( ) -	MESSAGE /CELL PHONE NUMBER ( ) -	WORK PHONE NUMBER ( ) -	E-MAIL ADDRESS

IN EMERGENCY NOTIFY (Name, Relationship, Address, Telephone)

CHILD'S Primary Care Practitioner — ADDRESS — PHONE NUMBER

REFERRED BY: (Name, address, phone) (This individual verifies that the child's parent/guardian has been notified about this referral.)

REASON FOR REFERRAL TO CRS:

LIST PRIMARY DIAGNOSES (e.g., Cleft Lip, VSD, Cerebral Palsy, etc.) IF AVAILABLE, **PLEASE SEND RECORDS WITH THIS FORM.**

1) 4)
2) 5)
3) 6)

LIST ANY KNOWN ALLERGIES

1) 2) 3) 4)

HAS CHILD RECEIVED CRS SERVICES BEFORE?: ☐ YES ☐ NO — YEAR? — WHERE? — PRIMARY LANGUAGE?

NAME OF PERSON WHO COMPLETED THIS FORM	ADDRESS	PHONE ( ) --	RELATIONSHIP TO PATIENT

PERMISSION TO OBTAIN RECORDS

I hereby authorize and request the CHILDREN'S REHABILITATIVE SERVICES through the authorized contractors, to request and obtain photocopies of medical records concerning the above named patient:

Obtain records from:
Primary Care Practitioner_____Address: _____

Specialist: _____ Address: _____

Specialist: _____ Address: _____

Therapist/Education: _____ Address: _____

This consent will expire one year after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify the Children's Rehabilitative Services clinic in writing to that effect. I understand that a photocopy or facsimile of this authorization is considered acceptable in lieu of the original.

_____ _____
Signature of Consenting Party Date Relationship to Patient

AHCCCS PLAN [ ] YES [ ] NO HEALTH INSURANCE [ ] YES [ ] NO *Please include copy of insurance information or card.*

FOR CRS CLINIC USE ONLY				
APPLICATION REVIEWED BY:			DATE	☐ Approved
SPECIALTY CLINIC ASSIGNMENTS:				
☐ PEND- **diagnostic tests**	☐ PEND- **waiting for medical documentation**	☐ DENY- **no medical documentation**	☐ DENY-**not medically eligible**	☐ DENY – **Other reason**

APPENDIX G:

EPSDT PERIODICITY SCHEDULE AND EPSDT FORMS

EXHIBIT 430-1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
EPSDT PERIODICITY SCHEDULE

EXHIBIT 430-1
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
EPSDT PERIODICITY SCHEDULE

PROCEDURES	INFANCY								EARLY CHILDHOOD					MIDDLE CHILDHOOD			ADOLESCENCE
	new born	2-4 day	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	8 yr	Yearly - age 10 up to age 21
History Initial/Interval	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Height & Weight	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Head Circumference	x	x	x	x	x	x	x	x	x	x	x						
Blood Pressure												x	x	x	x	x	x
Nutritional Assessment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Vision	SEE SEPARATE SCHEDULE																
Hearing/Speech	SEE SEPARATE SCHEDULE																
Dev./Behavioral Assess.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Physical Examination	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Immunization	← x	→		x	x	x		←	x	→			←	x →			← →
Tuberculin Test								+	+	+	+	+	+	+	+	+	+
Hematocrit/Hemoglobin			←	→			x										← 14 →
Urinalysis														x			← 14 →
Lead Screen																	
Verbal						x	x		x	x		x	x	x	x		
Blood								x			x	x*	x*	x*	x*		
Anticipatory Guidance	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Dental Referral	SEE SEPARATE SCHEDULE																

These are minimum requirements. If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

Key: x = to be completed + = to be performed for members at risk when indicated.

← x → = the range during which a service may be provided, with the x indicating the preferred age.

* Members not previously screened who fall within this range (36 to 72 months of age) must have a blood lead screen performed.

NOTE: If American Academy of Pediatrics guidelines are used for the screening schedule and/or more screenings are medically necessary, those additional interperiodic screenings will be covered

Revised 08/01/2005

EXHIBIT 430-1 (con't)

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DENTAL PERIODICITY SCHEDULE

	MONTHS	YEARS																		
PROCEDURE	Birth thru 12 months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+ up to 21
DENTAL REFERRAL	+	←		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

The American Association of Pediatric Dentistry recommends that dental visits begin by age one (1). PCP referrals for dental care are mandatory beginning at age three (3). Referrals should be encouraged by age one (1). Parents of young children may self refer to a dentist within the Contractor's network at any time.

AHCCCS covers subsequent examinations as prescribed by the dentist within the EPSDT standards.

Key: + = if indicated
x = to be completed

Revised 08-01-2005

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
VISION PERIODICITY SCHEDULE

	MONTHS											YEARS														
Procedure	New born	2 - 4 Days	by 1 mo	2	4	6	9	12	15	18	24	3*	4	5	6	8	10	11	12	13	14	15	16	17	18	19 up to 21 yrs
Vision +	S	S	S	S	S	S	S	S	S	S	S	O	O	O	S	S	O	S	O	S	S	S	S	S	O	S

These are minimum requirements: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key: S =Subjective, by history O = Objective, by a standard testing method
*** = If the patient is uncooperative, rescreen in 6 months.**
\+ = May be done more frequently if indicated or at increased risk.

Revised 08/01/2005

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HEARING AND SPEECH PERIODICITY SCHEDULE

	MONTHS											YEARS														
Procedure	New born	2 - 4 Days	by 1 mo	2	4	6	9	12	15	18	24	3	4	5	6	8	10	11	12	13	14	15	16	17	18	19 up to 21 yr
Hearing/ Speech+	S/O	S	S	S	S	S	S	S	S	S	S	O	O	O	S	S	O	S	O	S	S	S	S	S	O	S

These are minimum requirements: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key: S =Subjective, by history O = Objective, by a standard testing method
*** = All children, including newborns, meeting risk criteria for hearing loss should be objectively screened.**
\+ = May be done more frequently if indicated or at increased risk

Revised 08/01/2005

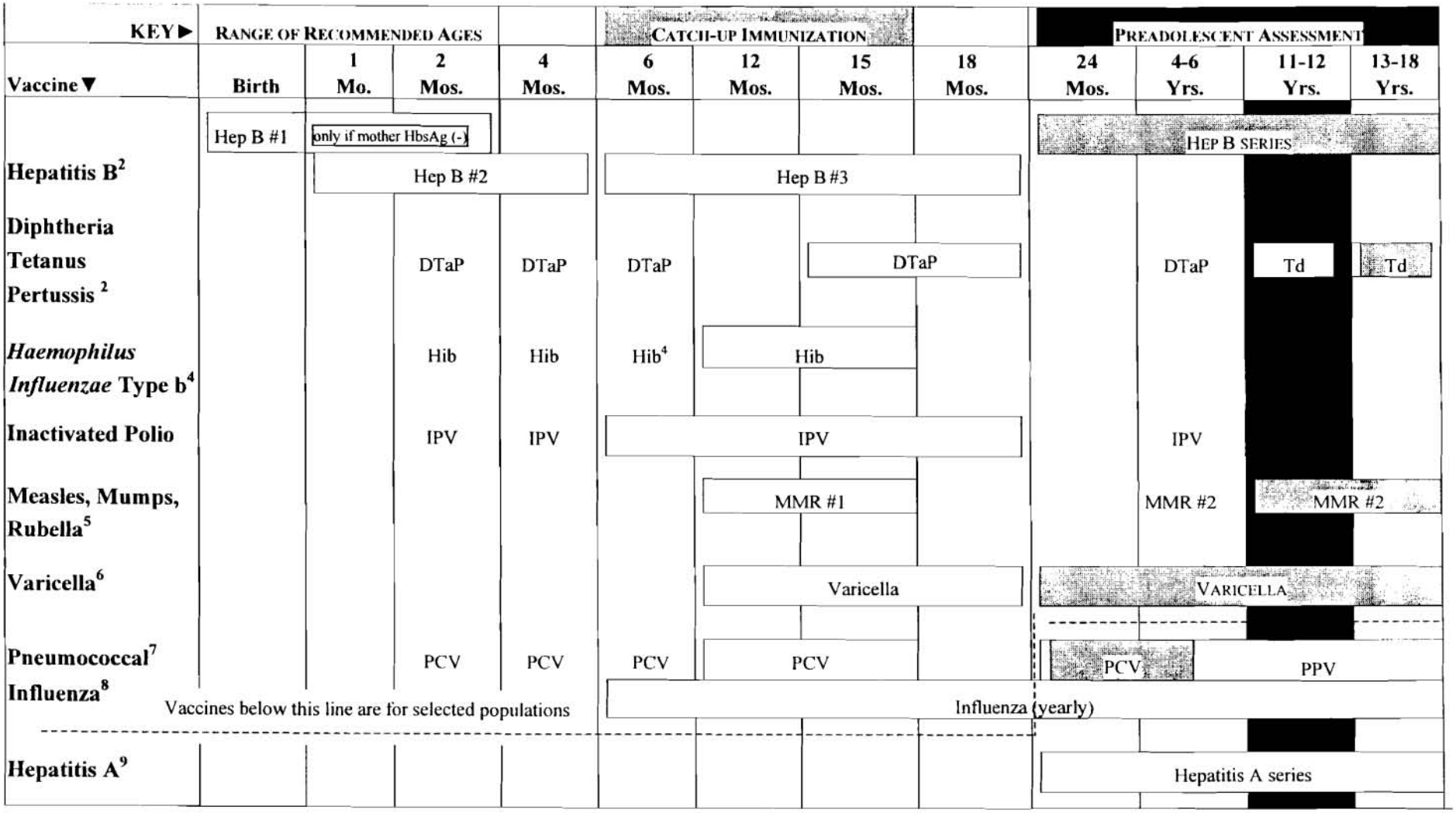
EXHIBIT 430-2

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE

EXHIBIT 430-2

RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE[1], BY VACCINE AND AGE

UNITED STATES, 2005



Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).
REVISED: December 1, 2004, June 2004

1. This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2004, for children aged ≤ 18 years. Any dose not administered at the recommended age should be given at any subsequent visit when indicated and feasible. The darker gray bars indicate age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines might be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated. Providers should consult package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS); guidance is available at www.vaers.org or by calling 1-800-822-7967.
2. **Hepatitis B (HepB) vaccine.** All infants should receive the first dose of HepB vaccine soon after birth and before hospital discharge; the first dose may also be administered by age 2 months if the infant's mother is Hepatitis B surface antigen negative (HBsAg) negative. Only monovalent HepB may be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be administered at least 4 weeks after the first dose, except for combination vaccines, which cannot be administered before age 6 weeks. The third dose should be administered at least 16 weeks after the first dose and at least 8 weeks after the second dose. The final dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks.
   Infants born to HBsAg-positive mothers should receive HepB and 0.5 mL Hepatitis B Immune Globulin (HBIG) within 12 hours of birth. The second dose is recommended at age 1-2 months. The final dose in the immunization series should not be administered before age 24 weeks. These infants should be tested for HbsAg and antibody to HBsAg at age 9 – 15 months.
   Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1 – 2 months. The last dose in the vaccination series should not be administered before age 24 weeks.
3. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) vaccine.** The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. The final dose in the series should be given at age ≥ 4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.
4. ***Haemophilus Influenzae* type b (Hib) conjugate vaccine.** Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHib® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at age 2, 4 or 6 months, but can be used as boosters following any Hib vaccine. The final dose in the series should be administered at age ≥ 12 months.
5. **Measles, mumps, and rubella vaccine (MMR).** The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and that both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.
6. **Varicella vaccine.** Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons age ≥13 years should receive two doses administered at least 4 weeks apart.
7. **Pneumococcal vaccine.** The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children age 2-23 months. It is also recommended for certain children age 24 to 59 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See MMWR 2000; 49(No. RR-9).
8. **Influenza vaccine.** Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, HIV and diabetes, health care workers, and other persons (including household members) in close contact with persons in groups at high-risk (see MMWR 2004; 53[No. RR-6]). In addition, healthy children aged 6 to 23 months and close contacts of healthy children aged 0 – 23 months are recommended to receive influenza vaccine, because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5 to 49 years, the intranasally administered live-attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See MMWR 2004; 53[No. RR-6]). Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if 6 to 35 months or 0.5 mL if ≥ 3 years). Children aged ≤ 8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).
9. **Hepatitis A vaccine.** Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions and groups who have not been immunized against hepatitis A can begin the hepatitis A vaccination series during any visit. The two doses in the series should be administered at least 6 months apart. See MMWR 1999; 48(No. RR-12).

Approved by the Advisory Committee on Immunization Practices (www.cdc.gov/nip/acip), the American Academy of Pediatrics (www.aap.org) and the American Academy of Family Physicians (www.aafp.org). Additional information about vaccines, including precautions and contraindications for vaccination and vaccine shortages, is available at http:\www.cdc.nip or from the National Immunization Information Hotline at 800-232-2522 (English) or 800-232-0233 (Spanish).

Revised: December 2004, June 2004

EXHIBIT 430-2 (CONTINUED)

FOR CHILDREN AND ADOLESCENTS WHO START LATE OR WHO ARE > 1 MONTH BEHIND, UNITED SATES, 2005

Catch-up schedule for children aged 4 months through 6 years.

Dose One (Minimum Age)	Minimum Interval Between Doses			
	Dose One to Dose Two	Dose Two to Dose Three	Dose Three to Dose Four	Dose Four to Dose Five
DtaP[1] (6 wk)	4 wk	4 wk	6 mo	6 mo[1]
IPV[2] (6 wk)	4 wk	4 wk	4 wk[2]	
HepB[3] (birth)	4 wk	8 wk (and 16 wk after first dose)		
MMR[4] (12 mo)	4 wk[4]			
Varicella (12 mo)				
Hib[5] (6 wk)	4 wk: if first dose administered at age <12 mo 8 wk (as final dose): if 1st dose administered at age 12 - 14 mo No further doses needed: if 1st dose administered at age ≥15 ms	4 wk[6]: if current age <12 mos. 8 wk (as final dose)[6]: if current age ≥12 mo and 2nd dose administered at age <15 mo No further doses needed: if previous dose administered at age ≥15 mo	8 wk (as final dose): this dose only necessary for children age 12 mo - 5 yrs. who received 3 doses before age 12 mo	
PCV[7] (6 wk)	4 wk: if first dose administered at age <12 mos and current age <24 mos 8 wk (as final dose): if 1st dose administered at age ≥12 mos or current age 24-59 mos No further doses needed: for healthy children if 1st dose administered at age ≥24 mos	4 wk: if current age <12 mo 8 wk (as final dose): if current age ≥12 mo No further doses needed: for healthy children if previous dose administered at age ≥24 mo	8 wk (as final dose): this dose only necessary for children aged 12 mo - 5 yrs. who received 3 doses before age 12 mo	

Catch-up schedule for children aged 7 through 18 years.

Minimum Interval Between Doses					
Dose One to Dose Two		Dose Two to Dose Three		Dose Three to Dose Four	
Td[8]:	4 wk	Td:	6 mo	Td[8]: 6 mo: if first dose administered at age <12 mo and current age <11 years. 5 yr: if first dose administered at age ≥12 mo and 3rd dose administered at age <7 yr and current age ≥11 yr. 10 yr: if third dose given at age ≥7 yr.	
IPV[9]:	4 wk	IPV[9]:	4 wk	IPV[2,9]	
HepB:	4 wk	HepB:	8 wk (and 16 wk after first dose)		
MMR:	4 wk[4]				
Varicella[10]:	4 wk				

Note: A vaccine series does not require restarting, regardless of the time that has elapsed between doses.

1. **DtaP**: The fifth dose is not necessary if the fourth dose was administered after the fourth birthday.
2. **IPV**: For children who received an all - IPV or all–oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was given at age ≥4 years. If both OPV and IPV were administered as part of a series, a total of four doses should be administered, regardless of the child's current age.
3. **HepB**: All children and adolescents who have not been immunized against hepatitis B should begin the HepB immunization series during any visit. Providers should make special efforts to immunize children who were born in, or whose parents were born in, areas of the world where hepatitis B virus infection is moderately or highly endemic
4. **MMR**: The second dose of MMR is recommended routinely at age 4 to 6 years, but may be administered earlier if desired.
5. **Hib**: Vaccine is not generally recommended for children ≥5 years.
6. **Hib**: If current age is <12 months and the first 2 doses were PRP - OMP (PedVaxHIB or ComVax[Merck]), the third (and final) dose should be given at age 12 to 15 months and at least 8 weeks after the second dose.
7. **PCV**: Vaccine is not generally recommended for children aged ≥5 years.
8. **Td**: For children aged 7 - 10 years, the interval between the third and booster dose is determined by the age when the first dose was given. For adolescents aged 11 to 18 years, the interval is determined by the age when the third dose was given.
9. **IPV**: Vaccine is not generally recommended for persons aged ≥18 years.
10. **Varicella**: Give 2-dose series to all susceptible adolescents aged ≥13 years.

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program website at www.cdc.gov/nip or call the National Immunization Hotline at 800-232-2522 (English) or 800-232-0233 (Spanish).

Revised 12/1/2004, 1/1/2004
Initial Effective Date 1/1/2003

AHCCCS EPSDT TRACKING FORMS

The AHCCCS EPSDT Tracking Forms must be used by providers to document all age-specific, required information related to EPSDT screenings and visits. Only the AHCCCS forms may be used; substitutes are not acceptable. AHCCCS Contractors are required to make these forms available to their contracted providers. Interested persons may refer to Chapter 400 in this Manual for a discussion of EPSDT responsibilities and services.

A copy of the completed form signed by the clinician should be placed in the member's medical record.

If the member is enrolled with an AHCCCS Contractor, a copy of the completed and signed form must be sent to that Contractor.

If the patient is an AHCCCS fee-for-service member (e.g., enrolled in Indian Health Services), the provider should maintain a copy of the EPSDT tracking form in the medical record, but does not need to send a copy elsewhere.

AHCCCS Contractors and AHCCCS medical providers may reproduce the EPSDT forms as needed. All others may reproduce the forms with permission of the Arizona Health Care Cost Containment System. Written requests for the Tracking Forms may be directed to:

AHCCCS
Division of Health Care Management
CQM/Maternal and Child Health
701 E. Jefferson, Mail Drop 6500
Phoenix, AZ 85034
(602) 417-4410

NOTE: The Centers for Medicare and Medicaid Services require AHCCCS to provide specified services to our EPSDT population. These EPSDT Tracking Forms have been designed to ensure that needed services are performed, and that our members are provided an opportunity to receive preventive care. *Please do NOT alter or amend these forms in any way without discussion with our Maternal and Child Health Manager at the address above.*

Contact information for AHCCCS' subcontracted health care plans may be found at www.ahcccs.state.az.us.

Revised 1/1/2004, 11/01/2003, 06/01/2003
Effective 07/01/2001

2 – 4 Day Old AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Birth Wt: | Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile

HISTORY:

Temp: _____
Pulse: _____
Resp: _____

Parental Comments/Concerns:

Nutritional Screen: Breast Feeding: _____ Formula (type): _____ Supplements: _____

Developmental Screen: Age Appropriate? (e.g., rooting reflex, startle, suck & swallow) Yes ____ No ____
If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes ____ No ____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing (Hospital screening done?)			
3. Eyes/Vision (red reflex)			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			
13. 2nd Newborn PKU (>72 hrs) prenatal labs/history			

ASSESSMENT & PLAN:

IMMUNIZATIONS:
- **Was Hepatitis B given at birth?** **Yes** _____ **No** _____
- **Pt. needs immunizations?** **Yes** _____ **No** _____
- **Shot Record initiated?** **Yes** _____ **No** _____

ANTICIPATORY GUIDANCE

- Supine sleep position
- Signs of illness
- Injury prevention
- Emergency/911
- Drowning prevention
- Passive smoke
- Car seat
- Parenting practices
- Postpartum adjustment
- Family involvement
- Infant bonding
- Next appt./transportation needed?

REFERRALS: **CRS** ____ **WIC** ____ **DDD** ____ **ALTCS** ____ **Specialty** _____ **Other** _____

Yes _____ No _____

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note:

Revised January 1, 2004

1 Month Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Birth Wt: | Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile:

HISTORY:

Temp: _____
Pulse: _____
Resp: _____

Parental Comments/Concerns:

Nutritional Screen: Breast Feeding: _____ Formula (type): _____ Supplements: _____

Developmental Screen: Age Appropriate? (e.g., responds to sounds, responds to parent's voice, follows with eyes?) Yes _____ No _____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes _____ No ___

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing (Hospital screening done?)			
3. Eyes/Vision (red reflex)			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			
13. Hemoglobin/Hematocrit (perform at 1-9 mos of age)			

ASSESSMENT & PLAN:

IMMUNIZATIONS:

Was Hepatitis B given at birth? **Yes** _____ **No** _____
Will 2nd Hep B be given today? **Yes** _____ **No** _____
Shot Record initiated? **Yes** _____ **No** _____

ANTICIPATORY GUIDANCE

- Supine sleep position
- Signs of illness
- Injury prevention
- Emergency 911
- Drowning prevention
- Passive smoke
- Car seat
- Parenting practices
- Postpartum adjustment
- Family involvement
- Infant bonding
- Next appt./transportation needed?

REFERRALS: **CRS** ____ **WIC** _____ **DDD** ___ **ALTCS** ___ **Specialty** _____ **Other** _____

Yes _____ No _____

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note?

Revised January 1, 2004

2 Month Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Birth Wt: | Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile:

HISTORY:

Temp: _____
Pulse: _____
Resp: _____

Parental Comments/Concerns:

Nutritional Screen: Breast Feeding: _____ Formula (type): _____ Supplements: _____

Developmental Screen: Age Appropriate? (e.g., smiles responsively, lifts head, vocalizes in play?) Yes ____ No ____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes ____ No ____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision (red reflex)			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			
13. Hemoglobin/Hematocrit (perform at 1-9 mos of age)			

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Delayed?** ____ **Deferred?** ____

Given today? Hep B ____ **DTaP** ____ **Hib** ____ **IPV** ____ **PCV** ____ **Other** _____

ANTICIPATORY GUIDANCE

- Supine sleep position
- Signs of illness
- Injury prevention
- Emergency/911
- Drowning prevention
- Passive smoke
- Car seat
- Dental gum care/bacteria
- Postpartum Adjustment
- Parenting Practices
- Family involvement
- Infant bonding
- Next appt./transportation needed?

REFERRALS: **CRS** ____ **WIC** ____ **DDD** ____ **ALTCS** ____ **Specialty** _____ **Other** _____

Clinician Name (print): | Clinician Signature: | Yes _____ No _____ See Additional/Supervisory Note?

4 Month Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Birth Wt: | Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile:

HISTORY:

Temp: _____
Pulse: _____
Resp: _____

Parental Comments/Concerns:

Nutritional Screen: Breast Feeding: _____ Formula (type): _____ Supplements: _____

Developmental Screen: Age Appropriate? (e.g., babbles & coos, rolls front to back, controls head well) Yes ___ No ___

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes ____ No ____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision (red reflex)			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			
13. Hemoglobin/Hematocrit (perform at 1-9 mos of age)			

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Delayed?** ____ **Deferred?** ____

Given today? Hep B ____ **DTaP** ____ **Hib** ____ **IPV** ____ **PCV** ____ **Other** _____

ANTICIPATORY GUIDANCE

- Supine sleep position
- Car Seat
- Injury prevention/rolling
- Emergency/911
- Drowning prevention
- Passive smoke
- Teething/choking/solid foods
- Dental gum care/bacteria
- Postpartum Adjustment
- Parenting Practices
- Family involvement
- Infant bonding
- Next appt./transportation needed?

REFERRALS: **CRS** ____ **WIC** ____ **DDD** ____ **ALTCS** ____ **Specialty** _____ **Other** _____

Clinician Name (print): | Clinician Signature: | Yes _____ No _____ See Additional/Supervisory Note?

Revised January 1, 2004

6 Month Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Birth Wt: | Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile:

HISTORY:

Temp: _____
Pulse: _____
Resp: _____

Parental Comments/Concerns:

Nutritional Screen: Breast Feeding: _____ Formula (type): _____ Supplements: _____ Solids: _____

Developmental Screen: Age Appropriate? (e.g., rolls over, transfers small objects, vocal imitation) Yes _____ No ____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes _____ No ____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision (red reflex)			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Hgb/Hct Yes ____ No ____

(Perform once during 1-9 mo age range)

SCREENINGS:

Verbal Lead Risk Assessment

Yes ____ No ____

(Perform at 6 mo of age)

ADDITIONAL LABS?

Specify:

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** ____ **Delayed?** _____ **Deferred?** _____

Given today? Hep B ____ **DTaP** ____ **Hib** _____ **IPV** ____ **PCV** ____ **Other** _____

ANTICIPATORY GUIDANCE

- Supine sleep position
- Drowning prevention
- Injury prevention
- Emergency/911
- Car Seat
- Passive smoke
- Finger Foods/Cup Use
- Teething/Tooth Brushing
- Postpartum Adjustment
- Parenting Practices
- Family involvement
- Interaction with Parents
- Next appt./transportation needed?

REFERRALS: **CRS** _____ **WIC** ____ **DDD** ____ **ALTCS** ____ **Specialty** _____ **Other** _____

Yes _____ No _____

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note?

Revised January 1, 2004

9 Month Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Birth Wt: | Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile:

HISTORY:

Temp: _____
Pulse: _____
Resp: _____

Parental Comments/Concerns:

Dental Screen: Brushing Teeth (minimal toothpaste)? Education re: white spots on teeth given? Yes _____ No _____

Nutritional Screen: Breast Feeding: _____ Formula (type): _____ Supplements: _____ Solids: _____

Developmental Screen: Age Appropriate? (e.g., pulls to stand, may say "mama/dada", crawls/creeps) Yes ___ No ___

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision (red reflex)			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Hgb/Hct Yes ___ No ___

(Required if not done previously)

SCREENINGS:

Verbal Lead Risk Assessment

Yes ___ No ___

(Perform at 9 mo of age)

ADDITIONAL LABS:

Specify:

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Delayed?** _____ **Deferred?** _____

Given today? Hep B ___ **DTaP** ___ **Hib** _____ **IPV** ___ **PCV** ___ **Influenza** _____ **Other** _____

ANTICIPATORY GUIDANCE

- Injury prevention
- Drowning prevention
- Mobility safety
- Emergency 911
- Car seat
- Passive smoke
- Finger foods/Self feeding
- Wean from bottle/cup use
- Postpartum adjustment
- Parenting practices
- Family involvement
- Interaction with parents
- Next appt./transportation needed?

REFERRALS: **CRS** _____ **WIC** _____ **DDD** ___ **ALTCS** ___ **Specialty** _____ **Other** _____

Clinician Name (print): | Clinician Signature: | Yes _____ No _____ See Additional/Supervisory Note?

Revised January 1, 2004

12 Month Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Birth Wt: | Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile:

HISTORY:

Temp: _____
Pulse: _____
Resp: _____

Parental Comments/Concerns:

Dental Screen: Daily tooth brushing? Yes _____ No _____ Education re: white spots on teeth given? Yes ____ No ____

Nutritional Screen: Breast Feeding: _____ Formula (type): _____ Supplements: _____ Solids: _____

Developmental Screen: Age Appropriate? (e.g., cruises, may take a few steps alone, precise pincer grasp) Yes ___ No ___

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes _____ No ____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:	LABS ORDERED:
1. Skin/Hair/Nails				Tuberculin Test
2. Ear/Hearing				Yes ____ No ____
3. Eyes/Vision (red reflex)				(perform if at risk)
4. Mouth/Throat/Teeth				
5. Nose/Head/Neck				**SCREENINGS:**
6. Heart				Blood Lead Test
7. Lungs				Yes ____ No ____
8. Abdomen				(perform at 12 mo of age)
9. Genitourinary				
10. Extremities				**ADDITIONAL LABS:**
11. Spine (scoliosis)				Specify:
12. Neurological				

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Delayed?** ___ **Deferred?** ___

Given today? **Hep B** ___ **Hib** ___ **IPV** ___ **MMR** ___ **Varicella** ___

PCV ___ **Influenza** ___ **Other** _____

ANTICIPATORY GUIDANCE

- Sleep practices
- Drowning prevention
- Injury prevention /911
- Car seat mobility
- Passive smoke
- Nutrition/Self feeding
- Wean from bottle/cup use
- Discipline/praise
- Postpartum adjustment
- Parenting practices
- Family involvement
- Interaction with parents/reading
- Next appt./transportation needed?

REFERRALS: **CRS** ___ **WIC** ___ **DDD** ___ **ALTCS** ___ **Specialty** _____ **Other** _____

Yes _____ No _____

Clinician Name (print): | Clinician Signature: | See Additional/Supervisory Note?

15 Month Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile:

HISTORY:

Temp: _____
Pulse: _____
Resp: _____

Parental Comments/Concerns:

Dental Screen: Daily toothbrushing? Yes _____ No _____ Education re: white spots on teeth given? Yes ____ No ___

Nutritional Screen: Breast/whole milk: _____ Table foods: _____ Supplements: _____ Cup: _____

Developmental Screen: Age Appropriate? (e.g., says 3-6 words, understands simple commands, climbs stairs) Yes ___ No ___

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes ____ No ____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision (red reflex)			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test
Yes _____ No _____
(perform if at risk)

SCREENINGS:

Verbal Lead Risk Assessment
Yes ____ No ____
(perform at 15 mo of age)

ADDITIONAL LABS:

Specify:

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Delayed?** _____ **Deferred?** _____

Given today? **Hep B** ____ **DTaP** ____ **Hib** ____ **IPV** ____ **MMR** _____

Varicella _____ **PCV** _____ **Influenza** _____ **Other** _____

ANTICIPATORY GUIDANCE

- Sleep practices
- Drowning prevention
- Injury prevention /911
- Car seat
- Passive smoke
- Nutrition
- Temper tantrums
- Discipline/limits
- Parenting practices
- Family involvement
- Interaction with parents/reading
- Next appt./transportation needed?

REFERRALS: **CRS** ____ **WIC** ____ **DDD** ____ **ALTCS** ____ **Specialty** _____ **Other** _____

Yes _____ No _____

Clinician Name (print): | Clinician Signature: | See Additional/Supervisory Note?

Revised January 1, 2004

18 Month Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile:

HISTORY:

Temp: _____
Pulse: _____
Resp: _____

Parental Comments/Concerns:

Dental Screen: Daily tooth brushing? Frequency of sugar intake & snacks low in sugar discussed? Yes ____ No ____

Nutritional Screen: Breast/whole milk: _____ Table foods: _____ Supplements: _____ Cup: _____

Developmental Screen: Age Appropriate? (e.g., uses a cup, walks backwards, says 10-20 words) Yes ____ No ____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes ____ No ____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision (red reflex)			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test
Yes ____ No ____
(perform if at risk)

SCREENINGS:

Verbal Lead Risk Assessment
Yes ____ No ____
(perform at 18 mo of age)

ADDITIONAL LABS:

Specify:

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** ____ **Delayed?** ____ **Deferred?** ____

Given today? **Hep B** ____ **DTaP** ____ **IPV** ____ **Varicella** ____ **Influenza** ____ **Other** _____

ANTICIPATORY GUIDANCE

- Sleep practices
- Drowning prevention
- Injury prevention /911
- Car seat
- Dental caries prevention
- Nutrition/mealtimes
- Sibling interaction
- Read to child
- Discipline/limits
- Parenting practices
- Family involvement
- Interaction with parents/reading
- Next appt./transportation needed?

REFERRALS: **CRS** ____ **WIC** ____ **DDD** ____ **ALTCS** ____ **Specialty** _____ **Other** _____

Clinician Name (print): | Clinician Signature: | Yes ____ No ____ See Additional/Supervisory Note?

24 Month Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile:

HISTORY:

Temp: _____
Pulse: _____
Resp: _____

Parental Comments/Concerns:

Dental Screen: Routine: _____ Urgent: _____ Parent advised: _____ Brushing teeth? Yes _____ No _____

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits (ABR, OAE): Yes ____ No ____ **Speech:** Within normal limits? Yes ____ No ____

Developmental Screen: Age Appropriate? (e.g., 20 word vocabulary, kicks ball, stacks 5 or 6 blocks) Yes ____ No ____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes ____ No ____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision (red reflex)			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test
Yes ____ No ____
(perform if at risk)

SCREENINGS:

Blood Lead Test
Yes ____ No ____
(perform at 24 mo of age)

ADDITIONAL LABS ORDERED:

Hgb/Hct Yes ____ No ____
Urinalysis Yes ____ No ____
Other:

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Delayed?** ____ **Deferred?** ____

Given today? **Hep B** ____ **Varicella** ____ **Hep A** ____ **PCV** ____ **Influenza** ____ **Other** _____

ANTICIPATORY GUIDANCE

- Sleep practices
- Drowning prevention
- Injury prevention /911
- Car seat
- Nutrition/exercise
- Sun safety
- Dental caries prevention
- Toilet training
- Read to child
- Family involvement
- Interaction with parents
- Next appt./transportation?

REFERRALS:

Behavioral _____ **Dental** _____ **Nutritional** _____ **Speech** _____ **DDD** _____ **ALTCS** _____ **CRS** _____

WIC _____ **Specialty** _____ **Developmental** _____ **Other** _____

Clinician Name (print): | Clinician Signature: | Yes ____ No ____ See Additional/Supervisory Note?

Revised January 1, 2004

3 Year Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Height: | Percentile: | BMI: | Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam:	**Temp:**
OD	**Pulse:**
OS	**Resp:**
OU	**BP**
Corrected / uncorrected	**BP Elevated?**

Dental Screen: Date of last exam: ____ Routine: ____ Urgent: ____ Parent advised: ____ Brushing child's teeth? Yes ____ No ____

Nutritional Screen: Adequate ____ Inadequate ____ Supplements: ____

Hearing Screen: Within normal limits? (ABR, OAE): Yes ____ No ____ **Speech:** Within normal limits? Yes ____ No ____

Developmental Screen: Age Appropriate? (e.g., jumps in place, knows own name, rides a tricycle) Yes ____ No ____

If suspicious, specific objective testing performed ____

Behavioral Screen: Age appropriate? (Pediatric Symptom Checklist, parental interview, observation) Yes ____ No ____

PHYSICAL EXAM

Are the following normal?	**Yes**	**No**	**Describe abnormal findings:**
1. Skin/Hair/Nails			
2. Ear Hearing			
3. Eyes/Vision			
4. Mouth/Throat/Teeth			
5. Nose Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test
Yes ____ No ____
(perform if at risk)

SCREENINGS:

Blood Lead Test
Yes ____ No ____
(Perform at 36-72 mo of age if not previously done)

ADDITIONAL LABS ORDERED:

Hgb/Hct Yes ____ No ____

Urinalysis Yes ____ No ____

Other:

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** ____ **Delayed?** ____ **Deferred?** ____

Given today? **Hep B** ____ **Varicella** ____ **PCV** ____ **Hep A** ____ **Influenza** ____ **Other** ____

ANTICIPATORY GUIDANCE

- Drowning prevention
- Sun Safety
- Car Seat
- Sport helmet use
- Nutrition/exercise
- Dental caries prevention
- Toilet training
- Passive smoke
- Reading/preschool
- Discipline
- Social interaction
- Family involvement
- Next appt./transportation?

REFERRALS:

Behavioral ____ **Dental** ____ **Nutritional** ____ **Speech** ____ **DDD** ____ **ALTCS** ____ **CRS** ____

WIC ____ **Specialty** ____ **Developmental** ____ **Other** ____

Yes ____ No ____

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note?

Revised January 1, 2004

4 Year Old — AHCCCS EPSDT Tracking Form

Date: | Last Name: | First Name: | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number: | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Height: | Percentile: | BMI: | Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam	
OD	
OS	
OU	
Corrected / uncorrected	

Temp:	
Pulse:	
Resp:	
BP	
BP elevated?	

Dental Screen: Date of last exam: _____ Next appt: _____ Routine ____ Urgent _____ Parent advised _____

Brushing child's teeth? Yes _____ No _____

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits (Audiometry, OAE): Yes ___ No ___ **Speech:** Within normal limits? Yes ___ No ___

Developmental Screen: Age Appropriate? (e.g., sings a song, draws person with 3 parts, gives first/last name) Yes ___ No ___

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (Pediatric Symptom Checklist, parental interview, observation) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test

Yes _____ No _____

(perform if at risk)

SCREENINGS:

Verbal Lead Risk Assessment _____

Blood Lead Test

Yes _____ No _____

(perform at 36-72 mo of age)

ADDITIONAL LABS ORDERED:

Hgb/Hct Yes _____ No _____

Urinalysis Yes _____ No _____

Other:

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Given today?** ___ **Delayed?** ___ **Deferred?** ___

Hep B ____ **DTaP** ____ **IPV** ____ **MMR** ____ **Varicella** ____ **Hep A** ____ **Influenza** _____ **Other** _____

ANTICIPATORY GUIDANCE

- Drowning prevention
- Sun safety
- Car seat
- Sport helmet use
- Nutrition/exercise
- Dental caries prevention
- Toilet training
- Passive smoke
- Reading/preschool
- "Safe at Home?"
- Social interaction
- Family involvement
- Next appt.?

REFERRALS:

Behavioral _____ **Dental** _____ **Nutritional** _____ **Speech** _____ **DDD** _____ **ALTCS** _____ **CRS** _____

WIC _____ **Specialty** _____ **Developmental** _____ **Other** _____

Clinician Name (print): | Clinician Signature: | Yes _____ No _____ See Additional/Supervisory Note?

http://www.ahcccs.state.az.us/Publications/GuidesManuals/BehavioralHealth/BehavioralHealthServicesGuide.pdf

5 Year Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Height: | Percentile: | BMI: | Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam	
OD	
OS	
OU	
Corrected / uncorrected	

Temp:	
Pulse:	
Resp:	
BP	
BP elevated?	

Dental Screen: Date of last exam: _____ Next appt: _____ Routine _____ Urgent _____ Parent advised _____

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits (Audiometry,): Yes ____ No ____ **Speech:** Within normal limits? Yes ____ No ____

Developmental Screen: Age Appropriate? (e.g., recognizes alphabet, able to run, skip & jump, can dress self) Yes ____ No ____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (Pediatric Symptom Checklist, parental interview, observation) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin Hair Nails			
2. Ear Hearing			
3. Eyes Vision			
4. Mouth Throat/Teeth			
5. Nose Head Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test _____ **(perform if at risk)**

Urinalysis _____ **(required)**

SCREENINGS

Verbal Lead Risk Assessment _____

Blood Lead Test _____ **(Perform at 36-72 mo of age)**

ADDITIONAL LABS ORDERED:

Hgb/Hct Yes ____ No ____

Other:

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Given today?** ___ **Delayed?** ___ **Deferred?** ___

PCV ___ **Hep B** ___ **DTaP** ___ **IPV** ___ **MMR** ___ **Varicella** ___ **Hep A** ___ **Influenza** ___ **Other** ___

ANTICIPATORY GUIDANCE

- Drowning sun safety
- Car seat seat belts air bags
- Sport bike helmet use
- Street safety
- Nutrition/exercise
- Tooth brushing twice/day
- Passive smoke
- Reading
- School readiness
- "Safe at Home?"
- Social interaction
- Family involvement
- Next appointment

REFERRALS:

Behavioral _____ **Dental** _____ **Nutritional** _____ **Speech** _____ **DDD** _____ **ALTCS** _____ **CRS** _____

WIC _____ **Specialty** _____ **Developmental** _____ **Other** _____

Yes _____ No _____

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note?

6 Year Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Height: | Percentile: | BMI: | Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam	
OD	
OS	
OU	
Corrected / uncorrected	

Temp:	
Pulse:	
Resp:	
BP	
BP elevated?	

Dental Screen: Date of last exam: _____ Next appt: _____ Routine _____ Urgent _____ Parent advised _____

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits? (Audiometry): Yes ____ No ____ **Speech:** Within normal limits? Yes ____ No ____

Developmental Screen: Age Appropriate? (e.g., school attendance, reading at grade level) Yes ____ No ____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (Pediatric Symptom Checklist, parental interview, observation) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin Hair Nails			
2. Ear Hearing			
3. Eyes Vision			
4. Mouth Throat/Teeth			
5. Nose Head Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test _____

(perform if at risk)

SCREENINGS

Verbal Lead Risk Assessment _____

Blood Lead Test _____

(perform at 36-72 mo of age)

ADDITIONAL LABS ORDERED:

Hgb/Hct Yes ____ No ____

Urinalysis Yes ____ No ____

Other:

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Given today?** ___ **Delayed?** ___ **Deferred?** ___

Hep B ____ **DTaP** _____ **IPV** _____ **MMR** _____ **Varicella** ___ **Hep A** ___ **Influenza** ____ **Other** ____

ANTICIPATORY GUIDANCE

- Drowning sun safety
- Seat belts air bags
- Sport bike helmet use
- Sports/injury prevention
- Street safety
- Nutrition/exercise
- Dental care/sealants
- Age appropriate behavior
- Social interactions
- "Safe at Home?"
- Family involvement
- Next appointment

REFERRALS:

Behavioral _____ **Dental** _____ **Nutritional** _____ **Speech** _____ **DDD** _____ **ALTCS** _____ **CRS** _____

Specialty _____ **Developmental** _____ **Other** _____

Yes _____ No _____

Clinician Name (print): | Clinician Signature: | See Additional/Supervisory Note?

Revised January 1, 2004

8 Year Old — AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Height: | Percentile: | BMI: | Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam	**Temp:**
OD	**Pulse:**
OS	**Resp:**
OU	**BP**
Corrected uncorrected	**BP elevated?**

Dental Screen: Date of last exam: _____ Next appt: _____ Routine _____ Urgent _____ Parent advised _____

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits? (Audiometry): Yes ___ No ___ **Speech:** Within normal limits? Yes ___ No ___

Developmental Screen: Age Appropriate? (e.g., school attendance, reading at grade level) Yes ___ No ___

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (Pediatric Symptom Checklist, parental interview, observation) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear Hearing			
3. Eyes Vision			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test _____

(perform if at risk)

ADDITIONAL LABS ORDERED:

Hgb/Hct _____

Urinalysis _____

Other:

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Delayed?** ___ **Deferred?** ___

Given today? **Hep B** _____ **PCV** ___ **Hep A** ___ **Influenza** _____ **Varicella** _____ **Other** _____

ANTICIPATORY GUIDANCE

- Drowning sun safety
- Seat belts air bags
- Sport bike helmet use
- Sports/injury prevention
- Street safety
- Nutrition/exercise
- Dental care
- Age appropriate behavior
- Social interactions
- "Safe at Home?"
- Family involvement
- Next appointment

REFERRALS:

Behavioral _____ **Dental** _____ **Nutritional** _____ **Speech** _____ **DDD** _____ **ALTCS** _____ **CRS** _____

Specialty _____ **Developmental** _____ **Other** _____

Clinician Name (print): | Clinician Signature: | Yes _____ No _____ See Additional/Supervisory Note?

Revised January 1, 2004

10-13 Year Old — AHCCCS EPSDT Tracking Form

Date | Last Name: | First Name: | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number: | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Height: | Percentile: | BMI: | Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam	
OD	
OS	
OU	
Corrected / uncorrected	

Temp:	
Pulse:	
Resp:	
BP	
BP elevated?	

Dental Screen: Date of last exam: _____ Next appt: _____ Routine _____ Urgent _____ Parent advised _____

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits? Yes ____ No ____ **Speech:** Within normal limits? Yes ____ No ____

Developmental Screen: Age Appropriate? (e.g., school attendance, reading at grade level) Yes ____ No ____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (HEADDSS, GAPS, parental interview) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear Hearing			
3. Eyes Vision			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary/Breast **Tanner Stage**			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test _____

(perform if at risk)

ADDITIONAL LABS ORDERED:

Hgb/Hct _____

Lipid profile _____

Urinalysis _____

Other

Confidential Documentation:

See attached note please _____

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** ____ **Delayed?** ____ **Deferred?** ____

Given today? **Hep B** ____ **Td** ____ **MMR** ____ **Influenza** _____ **Varicella** ____ **Hep A** ____ **Other** _____

ANTICIPATORY GUIDANCE

- Drowning sun safety
- Seat belts air bags
- Sports injury prevention
- Nutrition exercise
- Dental/flossing/self care
- Sex education
- Self control
- Peer refusal skills
- Social interaction
- Depression/anxiety
- Tobacco/alcohol/drugs/inhalants
- Violence prevention/gun safety
- Education goals/activities
- "Safe at Home?"
- Parenting advice
- Family involvement
- Next appointment

REFERRALS:

Behavioral ____ **Dental** ____ **Nutritional** ____ **WIC** ____ **Developmental** ____ **Specialty** ____ **Other** ____

Clinician Name (print): | Clinician Signature: | Yes _____ No _____ See Additional/Supervisory Note?

Revised January 1, 2004

14-17 Year Old — AHCCCS EPSDT Tracking Form

Date: | Last Name: | First Name: | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number: | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Height: | Percentile: | BMI: | Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam	
OD	
OS	
OU	
Corrected	uncorrected

Temp:	
Pulse:	
Resp:	
BP	
BP elevated?	

Dental Screen: Date of last exam: _____ Next appt: _____ Routine _____ Urgent _____ Parent advised _____

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits? Yes ____ No ____ **Speech:** Within normal limits? Yes ____ No ____

Developmental Screen: Age Appropriate? (e.g., school attendance, reading at grade level) Yes ____ No ____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (HEADDSS, GAPS, parental interview) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin Hair/Nails			
2. Ear Hearing			
3. Eyes Vision			
4. Mouth Throat/Teeth			
5. Nose Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary/Breast **Tanner Stage**			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test _____
(perform if at risk)

Urinalysis _____
(Perform at age 14)

Hgb/Hct _____
(Perform at age 14)

Additional Labs ordered:

Lipid profile _____

Other tests: _____

Confidential Documentation:

See attached note please: _____

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** ____ **Delayed?** ____ **Deferred?** ____

Given today? **Hep B** ____ **Td** ____ **MMR** ____ **Influenza** ____ **Varicella** ____ **Hep A** ____ **Other** _____

ANTICIPATORY GUIDANCE

- Drowning sun safety
- Seat belts driving safety
- Sports injury prevention
- Nutrition exercise
- Dental and self care
- Sex education/counseling
- Self control
- Peer refusal skills
- Social interaction
- Depression/anxiety
- Tobacco/alcohol/drugs/inhalants
- Violence prevention/gun safety
- Education goals/activities
- "Safe at Home?"
- Parenting advice
- Family involvement
- Next appointment

REFERRALS:

Behavioral ____ **Dental** ____ **Nutritional** ____ **WIC** ____ **Developmental** ____ **Specialty** ____ **Other** ____

Clinician Name (print): | Clinician Signature: | Yes _____ No _____ See Additional/Supervisory Note?

Revised January 1, 2004

18-21 Year Old — AHCCCS EPSDT Tracking Form

Date: | Last Name: | First Name: | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number: | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Height: | Percentile: | BMI: | Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam	
OD	
OS	
OU	
Corrected / uncorrected	

Temp:	
Pulse:	
Resp:	
BP	
BP elevated?	

Dental Screen: Date of last exam: _____ Next appt: _____ Routine _____ Urgent _____ Parent advised _____

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits? Yes _____ No _____ **Speech:** Within normal limits? Yes _____ No _____

Developmental Screen: Age Appropriate? Yes _____ No _____ If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (HEADDSS, GAPS, parental interview) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin Hair/Nails			
2. Ear Hearing			
3. Eyes Vision			
4. Mouth Throat/Teeth			
5. Nose Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary/Breast **Tanner Stage**			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test _____

(perform if at risk)

Additional labs ordered:

Hgb/Hct _____

Urinalysis _____

Lipid profile _____

Other tests: _____

Confidential Documentation:

See attached note please: _____

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** ____ **Delayed?** ____ **Deferred?** ____

Given today? **Hep B** ____ **Td** ____ **MMR** ____ **Influenza** ____ **Varicella** ____ **Hep A** ____ **Other** ____

ANTICIPATORY GUIDANCE

- Drowning sun safety
- Seat belts driving safety
- Sports injury prevention
- Nutrition exercise
- Dental and self care
- Sex education/counseling
- Self control
- Peer refusal skills
- Social interaction
- Depression/anxiety
- Tobacco/alcohol/drugs/inhalants
- Violence prevention/gun safety
- Education goals/activities
- "Safe at Home?"
- Parenting advice
- Family involvement
- Next appointment

REFERRALS:

Behavioral ____ **Dental** ____ **Nutritional** ____ **WIC** ____ **Developmental** ____ **Specialty** ____ **Other** ____

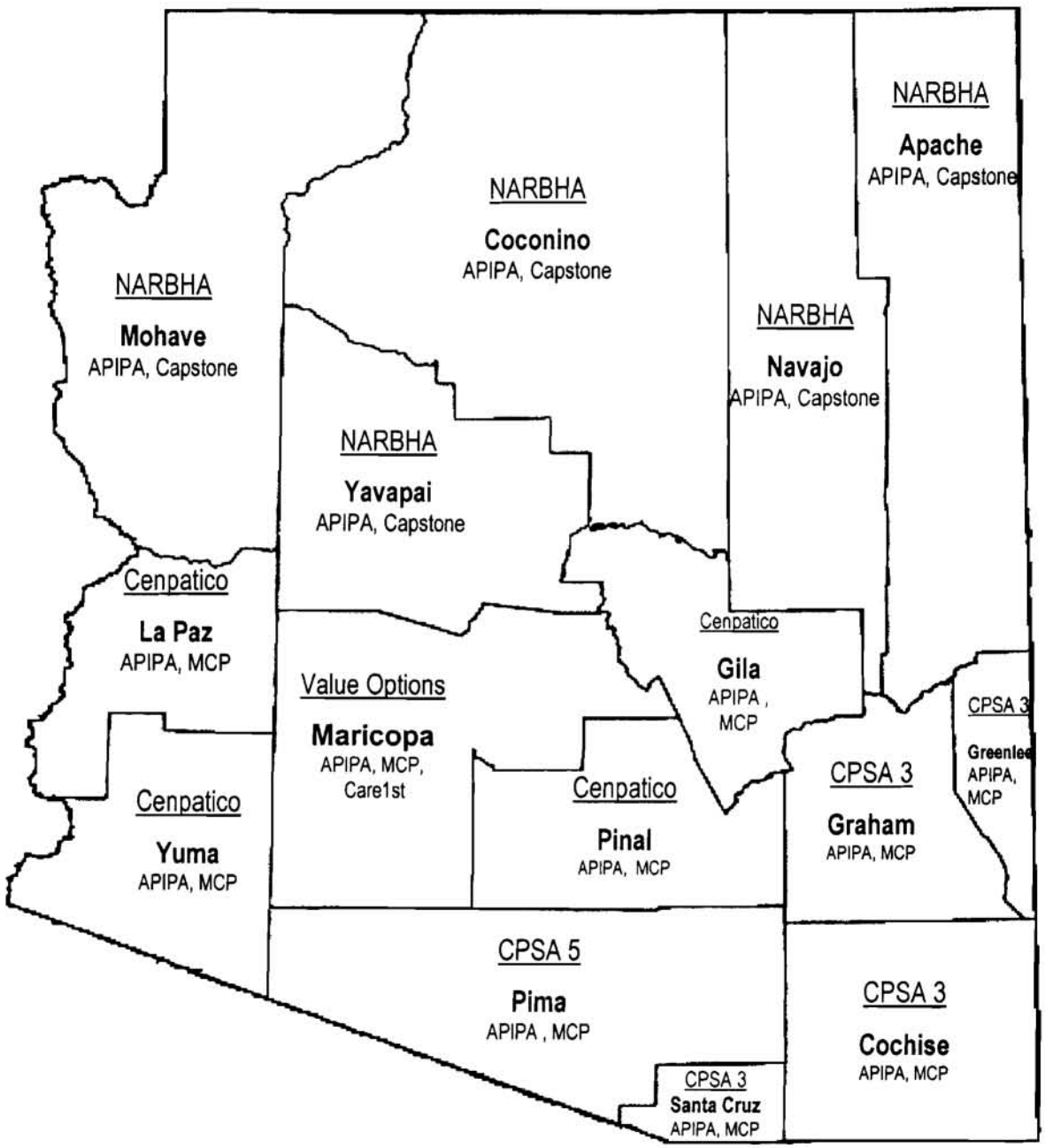
Clinician Name (print): Clinician Signature: Yes _____ No _____ See Additional/Supervisory Note?

Revised January 1, 2004

APPENDIX H:

MAP AND NAMES/TELEPHONE OF RBHAS/RBHA REFERRAL FORM

DES/DDD Map with Contracted Health Plans and RBHAs by County



NARBHA – Northern Arizona Regional Behavioral Health Authority
CPSA – Community Partnership of Southern Arizona
APIPA – Arizona Physician's I.P.A.
MCP – Mercy Care Plan
Capstone – Capstone Health Plan
CARE1st – Care1st Health Plan Arizona

REGIONAL BEHAVIORAL HEALTH AUTHORITIES (RBHAs) CONTACT NUMBERS

NAME	COUNTIES OF OPERATION	MEMBER SERVICES PHONE NUMBERS
Value Options 4444 N. 44th St., Suite 400 Phoenix, AZ 85008	Maricopa	Phone: (602) 914-5800 Info & Referral: (800) 564-5465 Fax: (602) 914-5811 24 hr Crisis Line: (602) 222-9444
Community Partnership of Southern Arizona (CPSA) 4575 E. Broadway Tucson, AZ 85711	Pima, Graham, Greenlee, Santa Cruz, Cochise	Phone: (520) 325-4268 Info & Referral: (800) 771-9889 Fax: (800) 443-0365 or (520) 326-0931 24 hr Crisis Line: (877) 756-4090
Northern Arizona Regional Behavioral Health Authority (NARBHA) 1300 S. Yale Street Flagstaff, AZ 86001	Coconino, Navajo, Apache, Yavapai	Phone: (928) 774-7128 Info & Referral: (800) 640-2123 Fax: (928) 774-5665 24 hr Crisis Line: (877) 756-4090
Cenpatico 1501 W. Fountainhead Parkway, Suite # 295 Tempe, AZ 85282	Pinal, Gila, La Paz, Yuma	Info Line: (866) 495-6738 Fax: (800) 398-6182 24 hr Crisis Line: (866) 495-6735

TRIBAL REGIONAL BEHAVIORAL HEALTH AUTHORITIES AND CONTRACTORS

NAME	MEMBER SERVICES NUMBER	WEB SITE ADDRESS
Pascua Yaqui Regional Tribal Behavioral Health Authority 7490 South Camino DeOeste Tucson, AZ 85746	(520) 879-6060	http://www.pascuayaqui-nsn.gov/community/programs/health/behavioral/index.shtml
Gila River Tribal Regional Behavioral Health Authority P.O. Box 38 Sacaton, AZ 85247	(520) 562-3321 or (602) 528-1206	http://www.gilariverrbha.org/index/htm

Navajo Nation Regional Behavioral Health Authority P.O. Box Drawer 709 Window Rock, AZ 86515	(928) 871-6877	http://www.navajo.org/

PM Form 3.3.1

ADHS/DBHS REFERRAL FOR BEHAVIORAL HEALTH SERVICES

I. Information on Person Making Referral Today's Date and Time_____

Name and Title_____

Affiliated Agency_____ Phone_____ Fax_____

Relationship with Person Being Referred_____

II. Information on Person Being Referred for Services

Name_____ Date of Birth _____ Age____ Gender ☐ F ☐ M

Address_____

City _____ State_____ Zip_____ Phone_____

Parent Legal Guardian (if applicable)_____ Phone_____

Identify individual(s) that the member, parent or guardian may wish to be invited to initial appointment with person (include phone)_____

Person Parent/Guardian is aware of referral: ☐No ☐Yes

Cultural and language considerations ☐No ☐Yes, specify language/need_____

Special Needs:

Mobility Assistance ☐No ☐Yes, identify assistance needed_____

Visual Impairment Assistance ☐No ☐Yes, identify assistance needed_____

Hearing Impairment Assistance ☐No ☐Yes, identify assistance needed_____

Developmental or Cognitive Impairment ☐No ☐Yes, identify assistance needed_____

Payment Source: ☐ AHCCCS ID #_____ ☐ Private insurance_____ ☐ Medicare

☐ Self pay ☐ Health Plan_____

PCP_____ Phone_____ Fax_____

Check any of the following which pertain to the person being referred:

☐ Shows evidence of suicidal or homicidal thoughts or behaviors ☐ Identified need for psychotropic medications

☐ Pregnant Woman ☐ Is currently hospitalized ☐ Was recently discharged from an inpatient setting

☐ Has immediate medical needs ☐ Other potential risk factors, e.g., dehydrated, malnourished, homeless

Reason for Referral, including an explanation of any items checked above_____

Additional information and contact information _____

If the person is taking medications to treat a behavioral health condition, does she/he have an adequate supply for the next 30 days? ☐ Yes ☐ No, if no, when will she/he exhaust the current supply of medications_____

III. Information to Be Completed by T/RBHA/Provider

Date Time Received _____

If applicable, name and contact information of the provider that will assume primary responsibility for the person's behavioral health care: _____

Type of Appointment ☐ Immediate ☐ Urgent ☐ Routine

☐ Available Intake Appointment Offered, specify date, time, place _____

Action Taken

☐ Scheduled Intake Appointment, specify date, time, place _____

☐ Not Referred for Appointment, specify why _____

☐ Other Disposition, explain _____

APPENDIX I:

CULTURALLY COMPETENT PATIENT CARE:

A GUIDE FOR PROVIDERS AND THEIR STAFF

CULTURALLY COMPETENT PATIENT CARE

A Guide for Providers and Their Staff

Institute for
Health Professions Education

Georgia G. Hall, Ph.D., MPH

OCTOBER 2001

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Cochise Health Systems

Health Choice Arizona

Institute for Health Professions Education

Lifemark Corporation Health Plan

Mercy Care Health Plan

Phoenix Health Plan

Pinal County Long Term Care

University Family Care

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David Brooks

TABLE OF CONTENTS

SECTION ONE

INTRODUCTION

This guide is intended to help Providers and their staff meet the challenge of caring for an increasingly diverse patient population, whose culture - which includes language, lifestyle, values, beliefs and attitudes may, differ from those of the dominant society.

Since these and other elements of culture influence the experience of illness, access to care, and the process of getting well, Providers and their staff are compelled to learn about them and incorporate that knowledge into the patient care plan.

Cultural competence can be defined as a combination of knowledge, clinical skills and behaviors that lead to positive outcomes of patient care with ethnically and culturally diverse populations.

Central to cultural competency is the provision of services, education and information in appropriate languages and at appropriate comprehension and literacy levels.

Benefits of a culturally competent approach to care:

- Devise more appropriate plans of care
- Improve quality of patient care and outcomes
- Reduce patient non-compliance
- Improve patient satisfaction
- Provide enhanced individual and family care
- Gain sensitivity to patient needs
- Work more effectively with diverse patient populations
- Adhere to federal and state requirements

HEALTH BELIEFS, ATTITUDES, AND BEHAVIORS: IMPLICATIONS FOR CLINICAL CARE

Culturally competent healthcare

An understanding of value systems and their influence on health is essential to providing culturally competent healthcare. Every culture has a value system that dictates behavior directly or indirectly by setting and encouraging specific norms. Health beliefs and practices, in particular, reflect that value system.

Providing care for patients from diverse backgrounds requires understanding one's own values as well as the values of other groups. There is a natural tendency for people to be culture bound, that is, to assume that their values, customs, attitudes and behaviors are always appropriate and right.

The following list, comparing dominant Anglo–American values with those of more traditional cultures demonstrates their differing views.

Anglo-American	More traditional cultures
Personal control over environment	Fate
Change	Tradition
Time dominates	Human interaction dominates
Human equality	Hierarchy/rank/status
Individualism/privacy	Group welfare
Self-help	Birthright inheritance
Competition	Cooperation
Future Orientation	Past orientation
Action/goal/work Orientation/informality	"Being" orientation
Directness/openness/honesty	Formality
Practicality/efficiency	Idealism/Spiritualism

Source:
Cross-Cultural Counseling: A guide for Nutrition and Health Counselors, U.S. Department of Agriculture/US Department of Health and Human Services, Nutrition Education Committee for Maternal and Child Nutrition Publications, 1986.

General beliefs

- Beliefs about the cause, prevention, and treatment of illness vary among cultures. These beliefs dictate the practices used to maintain health. Health practices can be classified as folk, spiritual or psychic healing practices, and conventional medical practices. Patients may follow a specific process in seeking health care. Cultural healers may be used in addition to conventional medical care.

Understanding your values and beliefs

- Cross-cultural healthcare requires Providers and their staff to care for patients without making judgments about the superiority of one set of values over the other.

- Providers are not only influenced by the cultural values they were raised with, but also by the culture of medicine which has its own language and values. The complexity of the health care system today is time oriented, hierarchical and founded on disease management and the preservation of life at any cost. Realizing these values as part of the current medical culture will be useful when dealing with patients with different values.

Knowing your patient

- The difference between a Provider who is culturally competent and one who is culturally aware is in the service that person provides. A culturally competent Provider is aware of the cultural differences and even more aware of the individual and his or her personal needs.

Appreciate the heterogeneity that exists within cultural groups

- As studies about cultural and ethnic groups demonstrate, there are distinctive characteristics that contribute to their uniqueness. Knowledge about these unique characteristics is important to the development of culturally relevant programs.

- Since significant variability may exist between and among individuals from the same cultural and ethnic group, over-generalization is a danger. Such variability can be due to: age, level of education, family, rural/urban residence, religiosity, level of adherence to traditional customs, and for immigrant patients, degree of assimilation and acculturation.

The role of economics

- The culture of poverty is as important as a person's ethnicity, social status and cultural background. Economic status may influence the patient's ability to acquire medical supplies or other resources (such as running water, electricity, adequate space, healthful or specific diet, etc.) needed for continuity of care and wellness. Decisions that are made about lower income patients' care must be sensitive to the differing degrees of access to resources.

The role of religious beliefs

- Religious beliefs can often influence a patient's decision about medical treatment. Because of their religious faiths, patients may request diagnosis but not treatment. If a particular treatment is absolutely necessary, Providers may find it helpful to consult with the patient's spiritual leader. Patients who seek mainstream medical care may also seek treatment from healers in their culture. Rather than discouraging this, especially if the alternative treatment is not harmful, Providers and their staff may want to incorporate traditional healing into the general treatment plan.

The role of the family

- Traditional cultures place a greater emphasis on the role of the family. Decision-making about health issues may be a family affair. It can be helpful for Providers and their staff to take this into account as medical decision-making takes place.

- Questions to consider:

  1. How many family members can accompany the patient into the room?

  2. Should friends be allowed in the room?

  3. Who can or should be told about the patient's condition?

SECTION THREE

STRATEGIES AND APPROACHES IN ASSESSING PATIENT'S BELIEFS ABOUT HEALTH AND ILLNESS

Cultural assessment

Cultural assessment of the patient is an important step in identifying the patient's views and beliefs related to health and illness. Beliefs about the cause, prevention, and treatment of illness vary among cultures. Such beliefs dictate the practices used to maintain health. Studies have classified Health Practices into several categories: **folk practices**, **spiritual** or **psychic healing practices,** and **conventional medical practices**.

In addition to the general data collected from a patient, the following checklist may be helpful in gaining culturally specific information.

- ❑ Where were you born?
- ❑ If you were born outside the USA, how long have you lived in this country?
- ❑ Who are the people you depend upon the most for help? (Family members, friends, community services, church etc.)
- ❑ Are there people who are dependent on you for care? Who are they? What kind of care do you provide?
- ❑ What languages do you speak?
- ❑ Can you read and write in those languages?
- ❑ What is the first thing you do when you feel ill?
- ❑ Do you ever see a native healer or other type of practitioner when you don't feel well?
- ❑ What does that person do for you?
- ❑ Do you ever take any herbs or medicines that are commonly used in your native country or cultural group?
- ❑ What are they, and what do you take them for?
- ❑ What foods do you generally eat? How many times a day do you eat?
- ❑ How do you spend your day?
- ❑ How did you get here today?
- ❑ Do you generally have to arrange for transportation when you have appointments?

Cultural assessment (continued)

To help Providers and their staff conduct cultural assessments, the questionnaire below will help determine a patient's beliefs about his or her problem:

Tools To Elicit Health Beliefs

1. What do you call your problem? What name does it have?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?
5. How severe is it? Will it have a short or long course?
6. What do you fear most about your disorder?
7. What are the chief problems that your sickness has caused for you?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from treatment?

Further Questions to Consider

- Do individuals in this culture feel comfortable answering questions?
- When the Provider asks questions, does the patient, or family, perceive this as a lack of knowledge?
- Who should be told about the illness?
- Does the family need a consensus or can one person make decisions.
- Does the patient feel uncomfortable due to the gender of the Provider?
- Does more medicine mean more illness to the patient?
- Does no medication mean healthy?
- Does the patient prefer to feel the symptoms, or mask them?
- Does the patient prefer ONE solution or choices of treatment?
- Does the patient want to hear about risks?

(Source: Kleinman, Arthur A. Patients and Healers in the Context of Culture. The Regents of the University of California. 1981.

SECTION FOUR

EFFECTIVE PATIENT COMMUNICATION AND EDUCATION STRATEGIES

Communication

Intercultural communication is a key clinical issue in medicine and can determine quality of care. The language barrier is a particularly serious problem for Providers and patients alike. Since effective communication between patients and Providers is necessary for positive outcomes, the use of translators is essential.

Even with English speaking populations, it can be a challenge for the patient to try to understand the medical jargon that is commonplace among professionals in the healthcare setting. For example, words like "diet" have different meanings to professionals than they have in the general public.

Other Factors Influencing Communication:

Conversational style:	It may be blunt, loud and to the point – or quiet and indirect.
Personal space:	People react to others based on their cultural conceptions of personal space. For example, standing "too close" may be seen as rude in one culture and appropriate in another.
Eye contact:	In some cultures, such as Native American and Asian, avoiding direct eye contact may be a sign of respect and represents a way of honoring a person's privacy.
Touch:	A warm handshake may be regarded positively in some cultures, and in others, such as some Native American groups, it is viewed as disrespectful. Greeting with an embrace or a kiss on the cheek is common among some cultures.
Response to pain:	People in pain do not always express the degree of their suffering. Cultural differences exist in patient's response to pain. In an effort to "be a good patient" some individuals may suffer unnecessarily.
Time orientation:	Time is of the essence in today's medical practice. Some cultural groups are less oriented to "being on time" than others.

Other Factors Influencing Communication (Continued):

What's in a name: Some patients do not mind being called by their first name; others resent it. Clarify the patient's preference early on in the patient-Provider relationship.

Nonverbal communication: Messages are communicated by facial expressions and body movements that are specific to each culture. Be aware of variations in non-verbal communication to avoid misunderstandings.

When English is a second language: According to the US Census Bureau, 14% of Americans speak a language other than English in their home and 6.7 million people have limited or no English skills. As these numbers continue to grow, the need for multilingual care becomes more significant.

Patients with limited English proficiency may have more difficulty expressing thoughts and concerns in English and may require more time and patience. It is best to use simple vocabulary and speak slowly and clearly. Do not assume that because the patient can speak English that he can read and write in English as well. Remember, just because somebody speaks with a "perfect" American accent, doesn't mean that they will have complete and full mastery of the English language.

Translators: Often, volunteers from the community or relatives are brought by the patient to help with translation. Since patients may be reluctant to confide personal problems with non-professionals and may leave out important facts, this practice should be discouraged. Realize that it may be difficult for patients to discuss personal issues in front of a third non-professional party. The use of employees as translators (secretaries, house keeping etc.) may not be a better solution.

Translators should understand and speak a language well enough to manage medical terminology. The ideal translator is a professional. If a professional translator is not available, over the phone translation services can be used.

Enhancing cross-cultural communication

Communicate effectively:	Allow more time for cross-cultural communication, use translators who are not family members and ask questions about cultural beliefs.
Understand differences:	Realize that family integration is more important than individual rights in many cultures. Involve spiritual or religious advisors when appropriate. Be aware of your own cultural beliefs and biases. Be sensitive to your authority as a medical professional.
Identify areas of potential conflict:	Determine who is the appropriate person to make decisions and clarify and discuss important ethical disagreements with them.
Compromise:	Show respect for beliefs that are different from your own. Be willing to compromise about treatment goals or modalities whenever possible. Remember that taking care of patients from other cultures can be time-consuming and challenging. In almost all instances, however, the extra time and effort expended will result in more satisfied patients, families and professionals.

SECTION FIVE

CULTURAL RESOURCES AND INTERPRETATION/TRANSLATION SERVICES

ALL AHCCCS contracted Health Plans and Program Contractors provide a variety of cultural competency resources, including interpretation/translation services and cultural awareness training. Under the AHCCCS program, these organizations are required to provide interpretation/translation services to Providers and Members free of charge.

If you need interpretation/translation services for patient care or wish to receive more information about available cultural competency resources, please contact the patient's AHCCCS Health Plan or Program Contractor to make the necessary arrangements.

AHCCCS and its participating Health Plans and Program Contractors encourage you to use professional interpretation/translation services. Use of non-professional interpretation/translation services such as by bilingual staff and/or a patient's family member may jeopardize patient outcomes.

INTERNET Resources

There are many cultural competency resources available on the Internet. The following listing is intended for informational purposes only.

General Reference sites:

- AMA Cultural Competence Initiative - http://www.ama-assn.org/ethic/diversity/
- National Center for Cultural Competence: Bureau of Primary Health Care Component http://www.dml.georgetown.edu/depts/pediatrics/gucdc/nccc.html. Home page http://www.dml.georgetown.edu/depts/pediatrics/gucdc/cultural.html
- Ethnomed: University of Washington: cultural profiles, cross cultural topics, patient education http://healthlinks.washington.edu/clinical/ethnomed/
- http://www.baylor.edu/~Charles_Kemp//hispanic_health.htm Great site for information on Hispanic and other cultures (i.e. Bosnian refugees).

General Reference sites (continued):

- Society of Teachers of Family Medicine: Multicultural Health Care and Education http://stfm.org/corep.html. General curriculum information and listings of print, experiential exercises, games, simulations and video resources (not online). STFM homepage http://stfm.org/index.html

- AMSA (American Medical Student Association): http://www.amsa.org/programs/gpit/cultural.htm

- Cross Cultural Health Care Program (CCHCP) Site offers schedules/location/fees of cultural competency training, interpreter training, research projects, community collaboration, and other services. Online registration for training sessions, interpreter and translation services. http://www.xculture.org/

- Opening Doors: in progress - cultural issues of health care -will contain discussion forum on cultural issues in healthcare,articles, etc. http://www.opening-doors.org/

- Perspective of Difference: an interactive teaching module http://medicine.ucsf.edu/divisions/dgim/pods/html/main.html

- Bridge to Wellness: Cultural Competency http://www.serve.com/Wellness/culture.html. Homepage: www.serve.com/ Wellness -Developed for Adult Psychiatry- list of cultural competency principles for health care clinicians.

- U.S. Department of Health and Human Services: The Initiative to Eliminate Racial and Ethnic Disparities in Health http://raceandhealth.hhs.gov/

- National Institute of Health Office of Research on Minority Health http://www1.od.nih.gov/ormh/main.html

- Health and Human Services: Health Resources and Services Admin.: news articles http://www.hrsa.dhhs.gov/

- US Department of Health and Human Services: Office of Public Health and Sciences: Office of Minority Health Resource Center http://www.omhrc.gov/

- Bureau of Primary Health Care Supported Community Health Programs http://www.bphc.hrsa.dhhs.gov/databases/fqhc/fqhcquery.cfm

- The Center for Cross Cultural Health: (410 Church street, Suite W227, Minneapolis, MN 55455) http://www.umn.edu/ccch/

- Cross Cultural Health Care Program (Pacific Medical Clinics / 1200 12th Avenue South, Seattle, WA 98144-2790 / Phone: (206) 326-4161) http://www.xculture.org/

- Department of Health and Human Services / Health Resources and Services Administration / Bureau of Primary Health Care (4350 East-West Highway, Bethesda, MD 20814)

- Interface International: Provides publications and training tools (c/o Suzanne Salimbene, Ph.D. / 3821 East State Street, Suite 197, Rockford, IL 61108 / Phone: (815) 965-7535 / e-mail: IF4YOU@aol.com)

- Simulation Training System (218 Twelfth Street, Del Mar, CA 92014-0901) / Resources for Cross-cultural Health Care: http://www.diversityrx.org/

- National Urban League (Phone: 212-310-9000) or http://www.nul.org/

- African Community Health and Social League (Phone: (510) 839-7764) http://www.progway.org/ACHSS.html

General Reference sites (continued):

- Association of Asian Pacific Community Health Organizations (Phone: (510) 272-9536) http://www.aapcho.org
- National Coalition of Hispanic Health and Human Services Organizations / Phone: (202) 387-5000 http://www.cossmho.org
- Center for American Indian and Alaskan Native Health Phone: (410) 955-6931 / http://ih1.sph.jhu.edu/cnah/

  www.culturalorientation.net or www.erc.msh.org "Providers Guide to Quality and Culture)